General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Cudworth Health Centre, Carlton Street, Cudworth, BARNSLEY, South Yorkshire, S72 8ST

Pharmacy reference: 1096141

Type of pharmacy: Community

Date of inspection: 15/05/2019

Pharmacy context

This is a community pharmacy based in a health centre in the village of Cudworth in Barnsley, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. And it offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy's team members discuss and record errors that happen with dispensing. They are good at using this information to learn and make changes to their practice, to help prevent similar mistakes happening again. And there is evidence that the changes they make are effective.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members to complete training. And this helps them improve their knowledge and skills. They are allocated set times to complete their training. And they can tailor their training to their own needs.
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 several processes and procedures, so the team can manage the risks to its services. It generally keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns about its services. The pharmacy keeps people's private information safe. All the team members complete training so they know how to protect the welfare of children and vulnerable adults. The pharmacy's team members record errors that happen with dispensing. And they discuss their learning. They are good at using this information to learn and make changes to help prevent similar mistakes happening again. And there is evidence that the changes they make are effective.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs were reviewed every two years, which ensured they reflected the current practice. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP detailed who was responsible for performing each task. The team members knew how important it was to ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then let the team member know they had made an error. The team member identified what had happened to help them reflect on why it occurred and to help with their learning. The team members recorded details of their own errors on to an online error reporting system called Datix. The records included the time, date and causes of the error. The errors were analysed every month by either a pharmacy technician or the regular pharmacist. The analysis was done to try and identify if there were any common themes or patterns in the errors. The findings of the analysis were documented and filed for future reference. The team discussed the findings in a monthly team meeting.

The team discussed LASA (look-a-like, sound-a-like) medicines during the last meeting. The team found that they were sometimes mixing up these medicines when they were dispensing. E.g. prednisolone and propranolol, sertraline and sildenafil, and amitriptyline and amlodipine. The team decided to separate these medicines to reduce the risk of the errors happening again. And the number of similar errors had reduced. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference and the mistakes were reported to the superintendent pharmacist's team. The pharmacy had recently supplied a person with the incorrect insulin. The team members discussed the incident and implemented the use of 'therapy check' alert stickers. These stickers were attached to the prescriptions of people who were prescribed insulin. The stickers were designed to remind the team members to ask the pharmacist on duty to do a third and final check before supplying the medicine to the person.

The pharmacy had a notice attached to a wall in the retail area which detailed how people could make a complaint. The pharmacy organised an annual survey to find out what people thought about the service they received. But the team members could not give an example of how they had used the feedback to improve the pharmacy's services.

The pharmacy had appropriate professional indemnity insurance facilities. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The pharmacy kept a responsible pharmacist record which complied with legal requirements. It maintained records for private prescription and emergency supplies. But some people's details were recorded using sticky dispensing labels and not indelible ink. And so the details could be removed and would fade in time. The pharmacy retained certificate of conformities following the supply of an unlicensed medicine. But they were not always completed according to MHRA requirements.

A sample of controlled drug (CD) registers were looked at. It included completed headers and entries made in chronological order. The pharmacy maintained running balances. And they were checked every week. A random CD item was balance checked and verified with the running balance in the register (Durogesic 50mcg X five). The pharmacy completed a CD destruction register for patient returned medicines.

Confidential waste was placed into a separate bin to avoid a mix up with general waste. The waste was destroyed by a third-party contractor. The team completed annual information governance training. A privacy policy was displayed in the retail area.

All registrants had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) on safeguarding the welfare of vulnerable people. All other team members had completed training that was provided by the company. The team members gave several examples of symptoms that would raise their concerns. And to escalate these concerns they would discuss them with the pharmacist on duty, at the earliest opportunity. The team members had access to a safeguarding policy and handbook which guided them on how to manage or report a concern. And they had access to the contact details of key safeguarding leads.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right qualifications and skills to undertake the tasks within their role. And the team members effectively manage the workload. The pharmacy is good at supporting its team members to complete training. And this helps them improve their knowledge and skills. They are allocated set times to complete their training. And they can tailor their training to their own needs.

Inspector's evidence

The regular pharmacist was on duty during the inspection. And was supported by a full-time accuracy checking technician (ACT) and three part-time NVQ2 qualified pharmacy assistants. The ACT was also the pharmacy manager. Three part-time NVQ2 qualified pharmacy assistants, a full-time NVQ3 qualified pharmacy technician and two deliver drivers were not present. The regular pharmacist worked three days a week. Locum pharmacists were on duty on the days the regular pharmacist was absent. The team were observed supporting each other during the inspection. The pharmacy could ask for cover from team members from other local branches in the event of an emergency.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist’s absence.

The team members were actively encouraged to continue ongoing learning. The team members completed learning about pharmacy related topics such as medicines and health conditions through reading trade press materials and working through training modules that were provided by the company. The team members were given protected time to train. So, they were able to train without any distractions. The training modules were available on an online training portal called e-expert. Some of the modules were mandatory and some could be done voluntarily e.g. if a team member had an interest in a subject. A team member demonstrated her training record. It showed that she had completed 100 per cent of the mandatory modules.

Each team member was invited to attend a weekly team meeting. And they discussed topics such as targets, concerns, patient safety and company news. The manager reported they had recently scored low on a mystery shopper purchase. So, she had organised mock scenarios of purchases that people could make. And tested the team on how they would respond to the situation. The team were provided with a monthly company newsletter called ‘share and learn’. The newsletter detailed company news that the team were required to discuss during their weekly meetings. A recent example related to the newly updated medicines delivery criteria. The meetings were also a chance for the team to give feedback and suggest ways they could improve the services offered to people. A recent example of this related to changing the dispensed medicines retrieval area. This allowed them to reduce the time people were waiting for the team to find their medicines.

The team members received a performance review with their line manager every six months. The reviews were an opportunity team to give feedback on how to improve the pharmacy's service, discuss

various aspects of their performance, including what they had done well and what could be improved.

The team described how they would raise professional concerns. The pharmacy had a whistleblowing policy. So, the team members could raise a concern anonymously.

The team were asked to meet various targets. These included retail sales, prescription volume and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations completed. The team said that they did not feel under pressure to achieve the targets. And would only try to deliver a service if it was in the best interest of the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and is adequately maintained. The pharmacy's facilities allow people to have private conversations with the team.

Inspector's evidence

The pharmacy was on the ground floor of the health centre building. The premises portrayed a professional image. It was generally clean, hygienic and well maintained. The floor spaces were clear with no evident trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a signposted and sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has suitable processes to manage the delivery of its services. The pharmacy team members take extra care to identify people taking high-risk medicines. And they monitor and give these people advice. But they don't always give people the information they need to take their medicines safely, when they supply medicines in multi-compartmental compliance packs. The pharmacy has adequate processes in place to ensure that the medicines they supply to people are fit for purpose. It sources, stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy could be accessed from the health centre car park. The services on offer, and opening times were advertised in the front window. There were adequate seating facilities for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet which they used to signpost people requiring a service that the team did not offer. People could choose from a wide range of healthcare related leaflets to take away.

The pharmacy team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels.

The dispensary had a manageable workflow with separate, areas for the team members to undertake the dispensing and checking parts of the dispensing process. The team members used basked to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. They used different coloured baskets to indicate urgency and which prescriptions required delivery.

The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team members ensure that the medicine could not be supplied to people after the prescription had expired. The pharmacy used clear bags to store dispensed fridge and CD items which allowed the team to do a further check of the item against the prescription. And by the person during the hand out process.

The team identified people who were prescribed high-risk medicines by attaching 'therapy check' stickers to their prescriptions. And by highlighting the medicine on the prescription using a blue highlighter pen. A poster attached to a wall displayed a list of high-risk medicines. The pharmacist gave people who were supplied these medicines additional verbal counselling. The details of these conversations were recorded on people's medication records. INR levels were assessed and recorded for people who were supplied warfarin.

The team members knew about the pregnancy prevention programme for people who were prescribed valproate. And they demonstrated the advice they would give people in a hypothetical situation. The team members had access to leaflets and alert cards which were about the programme. And they gave these to any people who would benefit from information about the programme. The team had completed an audit to identify any people that met the criteria of the programme and found no

affected people.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. And these were supplied to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. They always checked with people if they required any items that they didn't supply in the packs. They recorded details of any changes, such as dosage increases/decreases, on the master sheets. But they did not provide any information which would help people visually identify the medicines. They did not supply patient information leaflets with the packs each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed advising them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team members checked the expiry dates of the stock every three months and they kept records of the activity. They used 'use this pack first' stickers to highlight medicines that were expiring in the next six months. And they recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once opened. And check that they were fit for purpose and safe to supply to people. The team members checked and recorded fridge temperatures each day. A sample seen was within the correct ranges.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software or scanners were available to assist the team to comply with the directive. The team members had recently read a new SOP on FMD.

The pharmacy obtained medicines from licenced wholesalers. Patient returned medicines were stored in medicinal waste bins. The pharmacy received drug alerts electronically and the team actioned them. The team members printed the alerts and stored them in a folder. They kept a record of the action they took following the recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people's confidentiality.

Inspector's evidence

Reference sources were available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs. The fridges used to store medicines were of appropriate sizes. Medicines were organised in an orderly manner.

The computers were password protected and access to peoples' records were restricted by the NHS smart card system. And the computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations.

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.