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: 26/01/2023

Pharmacy context

The pharmacy is attached to a large medical centre in Cudworth, near Barnsley. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including the NHS Hypertension Case Finding Service, seasonal flu vaccinations and the NHS New Medicine Service (NMS). And they deliver medicines to people's homes.

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 adequately identifies and manages risks associated with its services. And it has documented procedures to help it provide services effectively. Pharmacy team members understand their role in helping to protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. But they don't always identify why mistakes happen and so they may miss opportunities to make improvements to the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage the risks to its services. These were available electronically, although some pharmacy team members found it difficult to find the SOPs on the company's intranet system during the inspection. The superintendent pharmacist's (SI) office reviewed the procedures every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert training system. Pharmacy team members read the procedures, and they completed a test after reading each one. If they passed the test, they could complete the sign off process as having read and understood it. The pharmacy defined the roles of pharmacy team members in each SOP, and tasks were further defined by frequent discussions amongst pharmacy team members throughout the day. The pharmacy received a bulletin approximately every month from the company's professional standards team, called "Share and Learn", which communicated professional issues and learning from across the organisation following analysis of near miss and errors. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed the front of each bulletin to record that they had done so. A recent example had been sharing learning from a dispensing incident where someone had been provided with the incorrect dose of medicines following a calculation error.

The pharmacy was providing a busy NHS Blood Pressure Check (Hypertension Case Finding) Service. The pharmacist carried out face-to-face consultations with people to test their blood pressure. This helped to determine whether people had, or were at risk of developing, high blood pressure. The pharmacist then provided people with further help, including providing them with a machine to monitor their blood pressure at home over 24-hours or by referring them to their GP or hospital if necessary. The pharmacy had developed several referral pathways with their local GPs to enable them to quickly refer people for further help. The pharmacist kept comprehensive records of each consultation and its outcome. They explained that the pharmacy had started to see an increase in the number of people being referred by their GP as the benefit of the service to people became more apparent and widely recognised. The pharmacy had also been able to incorporate the NHS New Medicines Service to help support people who had been prescribed new medicines to treat high blood pressure after accessing the blood pressure service. This meant the pharmacy were able to closely support people in the early days of taking their new treatment to make sure they were achieving the best outcomes. And helping to quickly recognise and support people experiencing side effects. The pharmacy had considered the risks of delivering the blood pressure check service to people. The pharmacist explained how the team had assessed various risks, such as the suitability of the pharmacy's consultation room to deliver the service from, ensuring that people had completed the necessary training, the availability of the necessary

equipment, and having the correct SOPs in place. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines on the shelves, to help prevent the wrong medicines being selected. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. Pharmacy team members were unable to access the electronic records during the inspection. So, the quality of error reporting could not be assessed. Team members explained a recent error that had occurred where someone had been provided with the incorrect strength of medication. The different strengths of the medicine had already been separated on the pharmacy's shelves in response to a near miss error. So, team members were now highlighting prescriptions for uncommon strengths of all medicines to help raise people's awareness of the risks when dispensing.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally from people. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained a responsible pharmacist record, which was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins, which were periodically emptied by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. They completed mandatory confidentiality and information security training each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years. And team members trained to different levels according to their qualifications and responsibilities.

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 appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. Team members feel comfortable raising concerns with the right people if necessary. And they feel well supported by their colleagues and manager.

Inspector's evidence

During the inspection, the pharmacy team members present were the responsible pharmacist (RP) manager, a pharmacy technician, two qualified dispensers and a trainee dispenser. Pharmacy team members completed mandatory e-learning modules ad hoc when sent by head office. These also included any new or updated standard operating procedures. Pharmacy team members also regularly discussed learning topics informally and the pharmacist highlighted topics for team members to learn more about. They sometimes took time during work to complete mandatory training. But they often chose to complete training at home in their own time because they felt more protected from distractions. Pharmacy team members received an appraisal with the pharmacy manager twice a year. They had a meeting with the manager to monitor their progress, allowing them to reflect on their own performance and identify their own learning needs.

Pharmacy team members explained they would usually raise professional concerns with their pharmacist or area manager. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. One recent example was the team introducing a rota system to enable team members to rotate and work in the various areas of the pharmacy’s operation. They explained this meant they were able to practice their skills in all areas to help keep them up to date. The rota also provided a team member who was dedicated to helping people at the pharmacy counter. And this helped to protect other team members from being distracted while they were dispensing, which helped to reduce the risk of mistakes.

The manager explained the company set the team targets to achieve in various areas of the business. These included number of prescriptions items dispensed, the services they provided, and the number of people nominated to use the pharmacy to have their electronic prescriptions dispensed. The manager explained the team were given autonomy to manage their targets appropriately. The pharmacy had a whistleblowing policy. Pharmacy team members knew how to access the procedure.

Pharmacy team members communicated openly during the inspection. They were asked to achieved targets in various areas of the business, for example the number of prescription items dispensed, and the number of services being delivered. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely. And explained they were comfortable to have conversations with their area manager if they did not achieve their targets. Team members explained they used the company’s target monitoring system to discuss their progress at a weekly huddle. But they also used the system to discuss and celebrate their successes together. At each huddle, they also discussed their wellbeing and gave themselves a happiness score. Team members explained this gave them an opportunity to discuss any concerns or worries they had. Or enabled the

manager to initiate a private conversation with them if necessary. They explained how much they liked this approach to wellbeing because they were under no obligation to share their feelings. But they appreciated the support available if they chose to share their concerns and worries with their colleagues.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. And it has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage the pharmacy's services well to make sure that people receive the care they need. And they effectively use technology to help them do this. The pharmacy's services are accessible to people, including people using wheelchairs. It sources its medicines appropriately. And it has processes in place to help people manage the risks of taking high-risk medicines.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy had a good proportion of its prescriptions dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. They continued to dispense prescriptions for urgent acute items, such as antibiotics, for medicines stored in the fridge and for prescriptions for unusual quantities of medicines. They used the hub most commonly for people's regular repeat medication. Pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and the patients leaving without all their prescription. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously.

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. The pharmacist clinically checked each prescription received in the pharmacy. And they annotated prescriptions to confirm they had completed their checks. A pharmacy technician was qualified to perform the final accuracy check of prescriptions. They explained they would not carry out final accuracy checks unless the clinical check had been completed. They also gave clear examples of the

types of prescriptions they were not permitted to check, such as prescriptions for controlled drugs and prescriptions for some high-risk medicines, such as methotrexate. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if they were at risk. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. Pharmacy team members were currently undertaking an audit of people who received valproate from the pharmacy. And this would help to ensure that the right people had received the appropriate information and counselling.

Pharmacy team members were aware of the necessary steps to take and the questions to ask people to make sure they supplied medicines to people safely over the counter. They clearly explained their limitations and gave examples of the types of requests they would refer to the pharmacist. These included referring requests for codeine-based products, chloramphenicol and pseudoephedrine. Team members were aware of local substance misuse services where they could refer people to for help and support. And they gave some examples of instances where they had referred people to these services who were struggling with addiction to over-the-counter pain relief, such as co-codamol. The pharmacy also had information materials available for people about local Alcoholics Anonymous and other support networks which they could access if they were experiencing dependence and addiction.

The pharmacy supplied medicines for a small number of people in multi-compartment compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs 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 person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). Team members kept records of communications they had with the GP surgeries and others about people's medicines, to help resolve future queries quickly. The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for another local store. The pharmacy used an electronic system to manage and record deliveries and it uploaded information to the driver's handheld device. Pharmacy team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy. And they returned the medicines to the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items at the beginning of their month of expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

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 a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.