General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ash Grove Pharmacy, Ash Grove Medical Centre, England Lane, KNOTTINGLEY, West Yorkshire, WF11 0JA

Pharmacy reference: 1100147

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

This community pharmacy is within a large medical centre in the small town of Knottingley. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartment compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. And it provides a supervised methadone consumption service.

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 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 not all met	5.3	Standard not met	The pharmacy stores confidential material in an area where there is a significant risk of unauthorised access and where people using the room can see it.

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy has written procedures that the team mostly follows. And most of the team members have signed to say they have read the procedures. The pharmacy team members respond adequately when errors happen. And they discuss what happened and they usually act to prevent future mistakes. But they don't regularly record all errors, or the actions taken to prevent errors. This means the team may miss opportunities to help identify patterns and reduce mistakes. The team has received training on data protection. But it stores confidential waste in areas of the pharmacy people can access.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. Most of the team had signed to say they'd read, understood and would follow the SOPs. The pharmacy manager and one of the dispensers had not signed the SOP signature sheets. The pharmacy had up-to-date indemnity insurance.

On some occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. But the last record was in February 2019. A sample of the near miss error records completed found that the team did not record details of what had been prescribed and dispensed to help spot patterns. The team usually recorded what caused the error and their learning from it. But the section detailing the actions they had taken to prevent the error happening again referred to replacing the incorrect product. So, there was no information about the steps the team member had taken to prevent the error from reoccurring. The pharmacy team recorded dispensing incidents and discussed the incident with all the team members, so everyone was aware of the error and could learn from it. The team had discussed a recent error involving a product that came in three strengths. This medicine was rarely prescribed so the team attached a label when the stock arrived at the pharmacy highlighting the strength and to prompt the team members to check what they had selected.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern about the NHS services provided by the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that several registers did not have the header completed. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. The Responsible Pharmacist notice was wrong at the start of the inspection, this was corrected during the inspection. A sample of records of private prescription supplies looked at found that the prescriber's details were incorrect. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy displayed a

privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite. But there was a large amount of confidential waste waiting to be removed from the pharmacy. The team stored most of the confidential waste in the consultation room either bagged up or on the desk in the room.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist and pharmacy technician had completed level 2 training in 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery drivers would report any concerns about people they delivered to back to the team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to provide the pharmacy's services. And they support each other in their day-to-day work. The team members share information and learning. And they have some opportunities to complete ongoing training. The team members don't receive feedback on their performance. So, they may miss the opportunity to improve and identify new roles to help the safe and effective delivery of services.

Inspector's evidence

Regular locum pharmacists covered the opening hours. The pharmacy team consisted of full-time pharmacy technician, who was also the pharmacy manager and was training to be an accuracy checking technician (ACT), three full-time dispensers, a part-time trainee dispenser, a part-time medicines counter assistant (MCA), one full-time delivery driver and three part-time delivery drivers. The pharmacy had a vacancy for a full-time dispenser and for several months had been trying to recruit. During this time the team supported each other by working extra hours. The pharmacy manager often worked on a Sunday as the team was often very busy with out-of-hours prescriptions. At the time of the inspection two of the regular locum pharmacists, the pharmacy manager, two dispensers, the trainee dispenser and MCA were on duty. The pharmacy manager held morning huddles with the team to plan the day and delegate tasks to team members. The pharmacy manager regularly met with the GP team to discuss issues such as delays with getting prescriptions for people who had their medicines changed when discharged from hospital.

The pharmacy provided the trainees with some protected time to do their training. And it provided some extra training for all the team such as children's oral health. The pharmacy did not provide performance reviews for the team members. So, they didn't have a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The team had changed the system for managing the repeat dispensing service when the prescriptions changed from paper to electronic. This helped the team to prepare the prescriptions in advance before the person presented. And to manage some complaints the team received about delays with people getting the medicines through this service. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. But the team also used the room as an office. So, it was cluttered with paperwork including confidential waste waiting removal.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy gets its medicines from reputable sources. And it stores and manages its medicines appropriately. The pharmacy generally manages its services well. It keeps records of deliveries it makes to people. So, it can deal with any queries effectively. But the team members do not routinely carry out checks with people taking high risk medicines. To ensure the person understands what dose to take. And to confirm they have regular blood tests. These checks help ensure people can take their medicines safely.

Inspector's evidence

People accessed the pharmacy via a step-free entrance from the car park. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team had access to the internet to direct people to other healthcare services. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply.

The pharmacy provided multi-compartmental compliance packs to help around 90 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. And it kept a list of when people were due their packs. The team were currently working two weeks ahead in preparation for the busy Christmas period. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a room off the main dispensary to dispense and check the packs. This was away from the distractions of the retail area. The room was built after the team had seen a large increase in the number of packs. The room provided plenty of space for the team to work and had its own computer. The team labelled the packs, picked the stock and placed the items in to baskets. The team placed the baskets on dedicated shelves for the team members working on a Sunday to dispense the packs. As they were less busy with other jobs. The team added notes to the basket to highlight any missing items. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The team placed completed packs in bags with the date of supply written on. And stored them on shelves before transferring them to tote boxes labelled with the date of delivery. The team prepared the weekly supplies as four weeks together and stored completed packs in baskets labelled with the person’s name. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items and shared the information with the GP team.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The team highlighted the CD on the prescription, so everyone was alert to this. Especially when the prescription included other medicines not classified as CDs. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme

(PPP). The pharmacy did not have the PPP pack to provide people with information when required. The team did not routinely ask people on high-risk medicines such as warfarin for information such as latest blood test results and doses. And if this was provided the team did not record it on the electronic patient record (PMR).

The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock and kept a record of this. But the record was not available to see when the last date check was completed. The team used coloured stickers to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 28 October 2019 recorded. The team checked the temperatures each day for one of the fridges. And it used an electronic record on the computer to capture this. A sample looked at found they were within the correct range. The team updated the computer during the inspection to include the other fridge in the daily readings. The team stored dispensed medicines waiting to be checked in a dedicated section of the fridge. And marked the prescription to alert the pharmacist that there was a medicine in the fridge for checking. This meant the fridge lines were not kept out of the fridge for a prolonged period. The team stored completed prescriptions for fridge lines in baskets in alphabetical order. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team hadn't been informed when the pharmacy systems would be updated to meet the requirements of FMD. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy stores confidential material in an area where there is a significant risk of unauthorised access and where people using the room can see it. The pharmacy has the equipment it needs to provide safe services.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a large fridge to store medicines kept at these temperatures. The fridge had a glass door. This enabled stock to be viewed without prolong opening of the door. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The team used cordless telephones to make sure telephone conversations were held in private.

The pharmacy stored completed prescriptions away from public view. But it kept a large amount of confidential information in the consultation room waiting to be shredded. Large bundles of prescriptions and delivery sheets with people's addresses on were on the table in the consultation room. And empty bottles used to provide people with their methadone doses were kept in a medicine waste bin without the lid on. These still had the dispensing labels attached. The team kept records of deliveries to people's homes in the consultation room on open display. The door in to the consultation room was not locked. So, there was a risk of unauthorised access. And people using the consultation room could see other people's private information.

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.