General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Hoyland Centre, High Croft, Hoyland, BARNSLEY, South Yorkshire, S74 9AF

Pharmacy reference: 1107809

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

This is a community pharmacy in the same building as Hoyland Health Centre in the village of Hoyland, Barnsley. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including, a minor ailments service, needle exchange, dispensing of substance misuse prescriptions, 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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting its team members to complete training through protected training time. And this helps them improve their knowledge and skills.
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 processes and written procedures to identify and adequately manage risks to its services. And it generally keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns about its services. It asks people for their views in a survey. And it generally displays the results of these surveys. The pharmacy team members keep people's private information safe. And although not all team members complete training they know what to do if they have a concern about the welfare of children or vulnerable adults. The pharmacy's team members record errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

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 pharmacy kept the SOPs online. And they were reviewed on a two-year rolling cycle. A pharmacy assistant demonstrated her online record, which showed that she had read and understood all the SOPs that were relevant to her role.

The pharmacy had a process in place 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 that they had made an error. But the pharmacist did not give specific details of the error, so the team members identified what they had done wrong themselves. This helped the team member's learning. The team members were encouraged to record details of their own errors on to a log. But the pharmacist often made the record. The records included the time and date of the error. The details of the error were also recorded onto an online reporting system called Datix. The team didn't regularly record the causes of the errors. The error logs were analysed each month by the pharmacist. This was done to see if there were any patterns or common trends in the errors. Details of the analysis were documented and filed.

The team discussed the findings of the analysis each month in a team meeting. The team also regularly separated medicines after a series of errors had been made e.g. nicorandil 10mg and 20mg. And attached stickers to shelves in front of medicines that had been involved in a mistake to highlight the risks when dispensing. A monthly patient safety report document was seen. Each team member had read the document. The report explained that the team were required to have three team members involved in the dispensing process to ensure accuracy, i.e. one team member to produce the dispensing labels, one team member to select the stock and one team member to complete the accuracy check.

The pharmacy recorded details of dispensing incidents electronically on Datix. The team printed off the record for future reference. And the mistakes were reported to the superintendent pharmacist. The team had recently supplied a person with insulin which was out of date. The team identified the cause of the error was due to an ad-hoc stock date checking system. The team changed the process to date check all stock every three months.

The pharmacy had a notice attached to a wall in the retail area which contained information on how to make a complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. The results of a survey from 2017 was displayed on a wall in the retail area. And the results were generally positive. The team were unsure about the outcome from the 2018 survey. The pharmacy's main area for improvement was the time taken for the team to dispense prescriptions for people who waited in the pharmacy. The team members did not want to rush their dispensing process in case they made an error. And instead they were conscious to give people realistic waiting times to manage their expectations better.

The pharmacy had up to date indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained. And they were checked every week. A random CD item was balance checked and verified with the running balance in the register (Matrifen 50mcg patches X 15). A CD destruction register for patient returned medicines was regularly completed. But some CDs that had been returned in November 2018 were yet to be destroyed. A pack of oxycodone tablets had been returned to the pharmacy on 9 April 2019. But a record of the return had not been made. The pharmacy maintained correct records of private prescription and emergency supplies. The pharmacy retained certificate of conformities following the supply of an unlicensed medicine. But two certificates were seen that had not been completed according to MHRA requirements.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into two separate bins to avoid a mix up with general waste. The confidential waste was collected by a third-party contractor and destroyed periodically. Prescription medication waiting to be collected was stored in a way that prevented people’s confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn’t on view to the public. The computers were password protected. All the team members had completed an internal company training module which covered information governance (IG) and data security.

The pharmacist on duty had completed safeguarding training via the Centre for Pharmacy Postgraduate Education. The other team members were not sure if they had completed any training. 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. But the team did not have a guide or any other documentation available to them which guided them on how to manage or report a concern. The team members explained they could always call on the support of the staff in the health centre if they had any immediate concerns that they felt they could not act on accordingly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills to undertake the tasks within their role. And with the number of team members available and their skills, they manage the workload and provide the pharmacy's services. The pharmacy supports its team members to complete regular training to help them improve their knowledge and skills. They receive time in the working day to complete their training. And they can tailor their training to their own development needs.

Inspector's evidence

A relief pharmacist, three full-time pharmacy assistants, one part-time pharmacy assistant and the pharmacy manager were on duty at the time of the inspection. The manager worked full-time and was also a qualified pharmacy assistant. The regular full-time pharmacist, a part-time pharmacy assistant, a full-time pharmacy assistant and two delivery drivers also worked at the pharmacy but were not present for the inspection. One of the pharmacy assistants was training to become an accuracy checking technician. The pharmacy until recently provided double pharmacist cover every Thursday and Friday. But this had been reduced to one day of double cover every four weeks. The team members were able to work overtime to cover any planned or unplanned absences. The pharmacy could also borrow staff 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 felt they 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, discussing the topics with colleagues and by completing modules via the company ‘E-expert’ online portal. The E-expert portal contained a library of modules covering various healthcare related topics and SOPs. Some modules were mandatory, and others could be worked through voluntarily if team members had identified a learning need. Many of the modules could only be marked as finished if the team member working through it passed a short assessment. The assessments generally consisted of around 10 multiple choice questions. The team members were required to achieve a mark of around 80 per cent to pass the module. The team received protected training time during their contracted hours to complete their training.

The team used a communications diary to ensure good day-to-day communication between each other. And they attended monthly meetings. They discussed various topics during the meetings. Including patient safety, company news and were also able to give feedback to each other to help improve the service offered to people. Following a recent meeting the team implemented a paper-form near miss log. This was because the team had found it difficult to always find time to make the entries on the online Datix system.

The team members received a performance review with their line manager every 6 months. The

reviews were designed to allow the team to give feedback on how to improve the pharmacy's service, discuss various aspects of their performance, including what they had done well, what could be improved. And any learning needs they had identified. All team members had received a recent appraisal.

The team described how they would raise professional concerns. A whistleblowing policy was in place. 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 allows people to have private conversations with the team.

Inspector's evidence

The pharmacy was professional in its appearance. And was generally clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. There was 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. Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services to help people meet their health needs. It manages the delivery of its services with adequate processes. The pharmacy team members give people advice when they supply high-risk medicines. But they don't always supply people with written information to help them take their medicines safely. 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 was accessible for people from street level and from the waiting room of the health centre. The services on offer, and opening times were advertised in the front window. Seating was provided 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. A wide range of healthcare related leaflets were available for people to select and 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. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on 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. Baskets were available to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. The team 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 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 medication such as warfarin. And they were given additional verbal counselling by the pharmacist. The details of these conversations were recorded on people's medication records. INR levels were assessed, but not recorded. The team were aware of 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 previously 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. But they had ran out of their supply. And they were unsure about where they could obtain a new supply.

People could request 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 it 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 queried any discrepancies with the person's prescriber. The team always checked with people if they required any items that they didn't supply in the packs. The team recorded details of any changes, such as dosage increases and decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels. And this included information which would help people visually identify the medicines. The team did not supply patient information leaflets with the packs each month as required by law. The requirements were discussed during the inspection.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. A separate delivery sheet was used for controlled drugs. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

Owing slips were given to people on occasions when the pharmacy 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. The team members used 'short dated' 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. Fridge temperatures were checked and recorded daily. 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 several reputable sources. Drug alerts were received via email to the pharmacy and actioned immediately. The alerts were printed and stored in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

References sources were in place. 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. A Methameasure dispensing system was used to dispense methadone. The system was cleaned every two weeks and calibrated daily.

The computers were password protected and access to peoples' records were restricted by the NHS smart card system. 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.