General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Exel Chemist, 56 High Street, NORMANTON, WF6 2AQ

Pharmacy reference: 1107912

Type of pharmacy: Community

Date of inspection: 04/10/2019

Pharmacy context

This community pharmacy is in the centre of the large town of Normanton. The pharmacy has extended opening hours. And it is open seven days a week. The pharmacy dispenses NHS and private prescriptions. And it provides medication in multi-compartmental compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. And it provides a seasonal flu vaccination service.

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	2.1	Good practice	The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy regularly reviews the team's skill mix and team numbers in line with increased workload. And it has increased the number of pharmacists to help support the safe and effective delivery of pharmacy services.
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 identifies and manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has adequate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback which the team responds to. The team members have some level of training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team does not have all the information it could to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of recently updated standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team members had read and signed the previous SOP signature sheets to show they understood and would follow them. And they were reading and signing off the updated SOPs. The pharmacy had up-to-date indemnity insurance.

On most 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 errors. And the team member involved recorded their own error. A sample of the error records looked at found that the team did not record details of what had been prescribed and dispensed to help spot patterns. The team members recorded what caused the error. But they did not record their learning from it and actions they had taken to prevent the error happening again.

The pharmacy team recorded dispensing incidents on to the electronic patient record (PMR). One of the regular pharmacists explained that the pharmacy team had not had a dispensing incident in the last year. And that this was due to several checks incorporated by the team during the dispensing and checking processes. Dispensing errors reports from 2018 were seen. The pharmacy completed an annual patient safety report. The latest report described changes made by the pharmacy team. The changes included the team confirming the identity of the person using three confirmatory identifications rather than two, before handing over the person's medicines. The report named the three identity checks as the person's name, address and postcode. The report stated this approach ensured the team gave medicines to the correct person regardless of any similarities with people's names and addresses. The team were seen asking people for these three checks before handing over their medicines. The report included the team's safety priorities for the next 12 months. These included informing team members of medicines that looked and sounded alike (LASA) through the WhatsApp group. So, they were aware of this when dispensing and checking the medicine they had picked from the shelves.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it did not have any information to provide people with details on how to raise a concern. 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 drug (CD) registers looked at found that they met legal requirements. Several CD registers were coming loose from the folder that contained them. This ran the risk of losing these registers. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found they met legal requirements. The pharmacy had two Responsible Pharmacist notices on display, when it should only have one displayed. One notice was clearly displayed. The other notice was hidden behind a large display. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they mostly 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 did not display a privacy notice in line with the requirements of the GDPR. Most of the team had signed confidentiality agreements. The pharmacy had an information governance (IG) policy dated 24 July 2019. But the team had not signed the policy. The team separated confidential waste and shredded it at the pharmacy.

The pharmacy had procedures to provide the team with information on how to respond to a safeguarding concern. The team members had access to contact numbers for local safeguarding teams. The regular pharmacists had completed level 2 training in 2017, 2018 and 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2018. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy regularly reviews the team's skill mix and team numbers in line with increased workload. And it has increased the number of pharmacists to help support the safe and effective delivery of pharmacy services. The pharmacy provides extra training and feedback to team members on their performance. So, they can identify areas to develop their skills. The team members support each other in their day-to-day work. And they share information and learning particularly from errors when dispensing. So, they can improve their performance and skills.

Inspector's evidence

Three regular pharmacists covered the opening hours. The pharmacy had increased the number of pharmacist hours to support the increase in the pharmacy business. This resulted in double pharmacist cover for most of the opening hours during the week. So, the pharmacists could provide services such as the flu vaccination to many people. And undertake different tasks during the day so they were not always checking prescriptions. The pharmacy team consisted of a full-time pharmacy pre-registration student, five full-time dispensers, one part-time medicine counter assistant (MCA), one part-time trainee MCA and a full-time pharmacy apprentice who had started at the pharmacy two months earlier. The pharmacy was open for 100 hours each week. And it always had one team member on duty with the pharmacists during the opening hours. So, the pharmacist never worked alone. Several team members had worked at the pharmacy since it opened in 2011. At the time of the inspection three of the regular pharmacists, the pre-registration student, two of the full-time dispensers, the trainee MCA and pharmacy apprentice were on duty.

One of the regular pharmacists was the tutor for the pre-registration student. The two worked together to plan the pre-registration training. The student identified a gap in their knowledge of products sold over-the-counter (OTC) and counselling people. The team supported this by asking the student to help people presenting at the pharmacy requesting advice and asking to buy OTC medicines.

The pharmacy provided extra training for the team through online modules. And the team had completed training such as Children's oral health. The pharmacy held regular team meetings. And the team used a communication book to suggest topics for the next meeting and to share key pieces of information. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. And following a suggestion the team had rearranged some of the shelves holding stock to make it easier to locate medicines when dispensing. The pharmacy had some targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And 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 facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy particularly the dispensary was small with limited space to work. The team managed this by working well together. The team used baskets to hold prescriptions and separated keys tasks such as dispensing and checking. The pharmacy owners had installed shelves to create more dispensing space. The pharmacy had separate sinks for the preparation of medicines and hand washing. And it had alcohol gel for hand cleansing. The pharmacy had a large consultation room. The team used this for private conversations with people.

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 team members provide services that support people's health needs. They order medicines from reputable sources. And they store and manage medicines appropriately. The pharmacy generally manages its services well. But when the pharmacy delivers medicines to people's homes it doesn't always get signatures from people for the receipt of their medicines. So, it doesn't have a robust audit trail and cannot evidence the safe delivery of people's medicines. This could mean that errors and queries may be difficult to resolve.

Inspector's evidence

The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy provided the flu vaccination service against up-to-date patient group directions (PGDs). The PGDs provided the pharmacists with the legal authority to administer the flu vaccines. The flu vaccination service was popular with people who liked the convenience of the service. And the time the pharmacists spent with them. So, people could use this time to talk about their medicines or health concerns. The team supported the service by giving people clear instructions on how to complete the consent form that accompanied the service. This meant the pharmacist had the information to hand before administering the vaccine. And the person was not kept waiting before they received the vaccine.

The pharmacy provided multi-compartmental compliance packs to help around 100 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. The team usually received the prescriptions one week 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 members liaised with the person to check the times they took their medicines especially when the dose was once a day. And they referred to the list when dispensing and checking the packs to ensure the medicines were in the correct time slot. The team used a section of a small room to the rear of the main dispensary to dispense the medication. This provided some protection from the distractions of the main dispensary and retail area. The pharmacy owners had refitted the pharmacy to include this space. Previously the team had limited space in a small section of the pharmacy to prepare the packs. The dispensers picked the medicines and asked another dispenser to check the items selected before dispensing the medicines in to the packs. The team stored medicines for the weekly packs in baskets labelled with the person's name. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The pharmacy usually received copies of hospital discharge summaries. The team members checked the discharge summary for changes or new items. And they sent a copy to the GP teams for reference and to request a new prescription when required. The pharmacy team members arranged for the return of packs from the person when changes occurred to their medicines. And they requested prescriptions from the GP team, so they could send new packs to the person.

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 stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And it separated people's doses to reduce the risk of selecting the wrong one.

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 team members referred to the prescription when selecting medication from the storage shelves. So, they had a prompt to check what they had picked. The team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had a written procedure to support this. The pharmacy had the PPP pack containing information to give to people when required. And the pharmacy computers generated an alert for the team to print off and place in to the pharmacy bag with the dispensed medicines. The team asked people on high-risk medicine such as warfarin if they had a recent blood test and if the person knew the dose they should be taking. The team avoided specific directions on the dispensing label for warfarin. So, the person did not get confused with the directions given by the clinic.

The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. This involved circling the date on the prescription. 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. But several delivery records did not have a signature. So, the team did not have proof that the person had received the medication.

The pharmacy team checked the expiry dates on medicine stock. The team members used coloured dots to highlight medicines with a short expiry date. And they kept a list of products due to expire each month. The team put medicines with two to three months expiry on dedicated shelves. The shelves were labelled to show they contained short-dated stock. So, the team could use these first after checking the expiry date would last the length of the prescribed treatment. 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 Sytron with three months use once opened had a date of opening of 07 August 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. 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 procedures and equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team members had received training but had not started scanning FMD products. 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 actioned the alert and usually kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it mostly uses its facilities to protect people’s private information.

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 fridge to store medicines kept at these temperatures.

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 pharmacy stored completed prescriptions away from public view. And it usually held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.