General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy M, The New Surgery, Adwick Road, MEXBOROUGH, South Yorkshire, S64 0DB

Pharmacy reference: 1108531

Type of pharmacy: Community

Date of inspection: 08/07/2022

Pharmacy context

The pharmacy is in a surgery in the south Yorkshire town of Mexborough. It opens extended hours over seven days a week. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing a private ear care service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service.

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 identifies and manages the risks associated with most of its services effectively. It keeps people's confidential information secure. And it generally keeps the records it must by law. The pharmacy responds appropriately to the feedback it receives by sharing this with its team members. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had implemented its latest version of standard operating procedures (SOPs) to support its team members in delivering pharmacy services safely in 2021. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. A pharmacist director had assumed responsibility for the SOP review process. And the superintendent pharmacist (SI), who was RP on the day of inspection, explained that the company was looking at options to store SOPs and hold associated training records electronically. Practice observed throughout the inspection and conversations with team members found they worked in accordance with the SOPs. But not all team members had completed training records to confirm they had read and understood the SOPs.

Pharmacy team members engaged in some continual learning associated with managing adverse safety events. Near miss recording rates were low. And a team member confirmed there was an opportunity to increase the frequency of reporting particularly during busy periods. The near miss records made included details of the follow-up actions taken to reduce the risk of a similar mistake occurring. For example, reviewing stock placement and separating 'look-alike' and 'sound-alike' (LASA) medicines on the dispensary shelves. But due to shift patterns in the pharmacy team there was not always the opportunity to discuss this learning through structured all staff meetings. The pharmacy had a SOP to support team members in managing and responding to dispensing incidents. And the team retained evidence of incident reporting. The pharmacy had a complaints procedure. A notice behind the medicine counter informed people about how they could provide feedback or raise a concern about the pharmacy. And the pharmacy kept records associated with the feedback it received. It participated in a mystery shopper scheme. And it displayed feedback from the most recent mystery shopper experience in the dispensary for its team members to read. A member of the team discussed how they would manage and escalate feedback they received to either the manager or to the SI.

The pharmacy had procedures in place to support the safe handling of people's confidential information. And it held personal identifiable information securely. It shredded confidential waste onsite. Procedures related to safeguarding were available along with contact information for local safeguarding teams. Pharmacy team members had an understanding of how to recognise and report a safeguarding concern. And the RP provided examples where either himself or a member of the team had acted to help safeguard a person. The RP reported that all team members had completed safeguarding learning as required through the NHS Pharmacy Quality Scheme (PQS). Registered pharmacy professionals had completed at least level two safeguarding training, with some pharmacists completing additional training due to dual roles involving working in GP practices.

The pharmacy had up-to-date indemnity insurance arrangements in place. And the RP explained the pharmacy had reviewed its insurance arrangements when it had introduced new services. The RP notice displayed reflected the correct details of the RP on duty. A sample of other pharmacy records found some minor omissions in record keeping. For example, records of private prescriptions did not always include both the date of the prescription and date of dispensing. And RPs occasionally forgot to sign-out of the RP register at the end of the working day. The pharmacy maintained running balances within its CD register. It completed physical balance checks of all CDs against the register every one to three months. A physical balance check conducted during the inspection complied with the balance recorded in the CD register. The pharmacy did not regularly record the address of the wholesaler when entering a CD into the register as required. It kept a patient returned CD destruction register, and it maintained this to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. It supports its team members by encouraging opportunities to develop their knowledge and skills. Pharmacy team members demonstrate enthusiasm for their roles. And they are confident in sharing their thoughts and ideas to help drive up the standard of the services the pharmacy provides.

Inspector's evidence

On duty during the inspection was the RP, a pharmacy technician, a qualified dispenser and a delivery driver. The pharmacy also employed another two qualified dispensers, a trainee dispenser and an apprentice. The pharmacy split the working week between four regular pharmacists including the SI and a pharmacist director. It was short-staffed on the day of inspection due to a team member taking unplanned leave and another was on annual leave. But workload was up to date. The team prioritised workload associated with acute prescriptions and deliveries due for the same day. Tasks associated with the multi-compartment compliance pack service were managed ahead of delivery and collection dates.

The RP confirmed that pharmacy support staff enrolled on training were making suitable progress with their learning. Team members had the opportunity to engage in some continual learning related to their roles. For example, the pharmacy manager and a dispenser were enrolled on accuracy checking courses. And the pharmacy technician discussed the training and upcoming changes to her role with enthusiasm. A training certificate in the consultation room provided people using the ear care service with assurance that the team member consulting with them had completed specific training to provide the service. Pharmacy team members reported that an annual appraisal was due. The pharmacy had a whistle blowing policy in place and team members on duty discussed feeling able to feedback any concerns at work. One team member explained how they could escalate a concern about the pharmacy should they need to.

Pharmacy team members communicated well with each other. They had recognised that working shifts prevented some face-to-face handover and learning opportunities. To support with communication the team had introduced a communication diary. This included information related to workload and services. And team members checked the diary throughout the day and checked off tasks as they completed them. The pharmacy did not have specific targets associated with it services. The RP explained the focus was on providing a positive experience to people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean and secure. They provide an appropriate space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The premises were small, consisting of a medicine counter and a dispensary. The team managed workload well in the space provided. This included specific space set aside for the management of higher risk tasks associated with the supply of medicines in multi-compartment compliance packs. The pharmacy had a consultation room accessible off the waiting area it shared with the GP practice. The room was small but it provided enough space for holding private consultations.

The pharmacy was secure and clean. Work benches in the dispensary remained free from clutter. Pharmacy team members had access to appropriate hand washing facilities. Lighting throughout the premises was sufficient. And the pharmacy had appropriate heating arrangements. It was located directly opposite the main entrance to the surgery. Doors to the surgery were left open to provide ventilation into the building. And team members used a fan in the dispensary during warmer periods.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes its services appropriately. And it makes them accessible to people. The pharmacy obtains its medicines from reputable sources. And it generally stores these medicines safely and securely. The pharmacy team uses audit trails effectively to help manage the pharmacy's dispensing and medicine delivery service. And it provides people with relevant information about the medicines they are taking.

Inspector's evidence

People accessed the pharmacy through the main entrance of the GP surgery, via the onsite carpark. The pharmacy team worked well with surgery staff including the practice pharmacist. And the practice pharmacist made himself available to share examples of continual communication between the two teams. There was evidence of effective interventions when dispensing prescriptions. For example, pharmacists identified repeat prescriptions for reliever inhalers only, and these were flagged to the surgery for review. And the pharmacy had been part of a multi-disciplinary team review to support medicine compliance associated with a chronic condition. As a result of this review it had adapted the way it supplied the medicine. The pharmacy team made regular checks with people to ensure they required all medicines on their repeat prescriptions prior to dispensing taking place. And there was continual communication between the pharmacy team and prescribers at the surgery around stock issues. This helped ensure local pharmacies were likely to have the stock to fill a prescription. The pharmacy team provided examples of signposting to other health and social care services when it was unable to provide a service or supply a medicine.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them in a glass fronted cabinet behind the medicine counter. The RP had good supervision of the medicine counter from the dispensary. The pharmacy team had an understanding of monitoring checks associated with high-risk medicines. This included details of checks and counselling associated with the valproate pregnancy prevention programme. And the team had the necessary safety information to issue to people in the high-risk group when dispensing valproate. Pharmacy professionals had access to procedures and up-to-date patient group directions (PGDs) to support them in providing services safely and effectively. For example, copies of PGDs relating to the supply of emergency hormonal contraception (EHC) and varenicline tablets were readily available for pharmacists to refer to. The pharmacy had adapted the NHS procedures related to the ear care service when it had commenced its own private service. The pharmacy technician provided this service and demonstrated how she managed it. People signed consent forms and these included consent to share information with their own GP. But the pharmacy did not routinely share information following these private consultations, instead it encouraged people to make their GP aware.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. The pharmacy maintained an audit trail of the deliveries it made to people. It kept these records for three months to support it in answering any queries related to the service. The pharmacy retained prescriptions with assembled items so its team members could refer to them at the point of handout. And it had a separate area for holding baskets of part-assembled items that could not be completed until stock arrived.

The pharmacy planned workload associated with the multi-compartment compliance pack service well. One member of the team generally managed this service. And other dispensary team members were knowledgeable about how the service was provided and could complete record keeping and dispensing tasks as needed. The pharmacy had a patient profile record in place for each person on the service. These record sheets contained information about a person's medicine regimen. And the team used the sheets to record changes effectively. A sample of assembled compliance packs found the pharmacy routinely provided descriptions of the medicines inside on the backing sheet. But the pharmacy did not routinely attach the backing sheets to the compliance packs. This increased the risk of a backing sheet, containing key safety information, becoming detached from a compliance pack once it had been supplied to a person. The pharmacy supplied patient information leaflets (PILs) alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers. It stored these medicines in an orderly manner, within their original packaging, on shelves throughout the dispensary. The pharmacy stored CDs appropriately within a secure cabinet. It attached prescription forms to bags of assembled CDs held within the cabinet. This prompted additional checks when handing out the medicine. The pharmacy fridge was clean and a suitable size for the amount of medicines held inside. The pharmacy maintained fridge temperature records. But these did contain some gaps, particularly at weekends. The minimum and maximum temperatures recorded either side of these gaps were within two and eight degrees Celsius as required.

The pharmacy team completed regular date checking tasks and it recorded these on a rota. It clearly identified short-dated medicines with stickers. But a random check of dispensary stock found one out-of-date box of diabetic testing strips. The team generally annotated opening dates on bottles of liquid medicines to ensure these medicines remained fit to supply. But one bottle of carbocisteine oral solution with a shortened shelf life once opened was not annotated. Both medicines were brought to the attention of the RP and removed for safe disposal. The pharmacy had appropriate medicine waste bins and CD denaturing kits available. The team received medicine alerts by email. And could demonstrate how it checked and responded to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date reference resources available including the British National Formulary (BNF). Pharmacy team members had access to the internet. They accessed password protected computers and used NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving to the side of the medicine counter. And details on bag labels and prescription forms could not be read from the public area.

Pharmacy team members generally used appropriate counting and measuring equipment when dispensing medicines. But a plastic measure was available alongside British standard measures for the purpose of measuring liquid medicines. The RP took the opportunity to dispose of this uncalibrated measure during the inspection. The pharmacy had separate equipment available for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society. And the pharmacy procured the ear care irrigation equipment and otoscope following the specific requirements of a NHS service specification.

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.