General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bilton Pharmacy, 120 City Road, BRADFORD, West Yorkshire, BD8 8JT

Pharmacy reference: 1111785

Type of pharmacy: Community

Date of inspection: 08/11/2022

Pharmacy context

The pharmacy is in the suburbs of Bradford city centre. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines for people in multi-compartment compliance packs. And they deliver medicines to people's homes.

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 not all met	1.7	Standard not met	The pharmacy does not effectively manage all its confidential information to help protect it from unauthorised access. Pharmacy team members are aware of their responsibilities to help protect people's confidentiality. But they do not always act if there is a risk of information security being compromised.
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 not all met	4.3	Standard not met	The pharmacy doesn’t adequately protect all its medicines from unauthorised access. And the team does not identify and manage the risks associated with this.
5. Equipment and facilities	Standards not all met	5.2	Standard not met	The pharmacy does not have appropriate equipment to accurately measure liquid medicines. And it does not keep the measures it does have in a suitable condition to use.

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy mostly manages the risks associated with delivering its services. But it does not appropriately manage all of its confidential information to mitigate the risk of unauthorised access. Pharmacy team members understand their role to help protect vulnerable people. They sometimes record and discuss errors they make. But they do not fully analyse these errors. So, they may miss opportunities to learn and make effective changes to help make services safer.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks to most of its services. The superintendent pharmacist (SI) had reviewed the SOPs available in 2020. Some pharmacy team members had read some procedures since they were reviewed. But the team members present confirmed they had not read them all. And no team members had signed the procedures to confirm they had read and understood them. Pharmacy team member's roles were defined in a document kept with the SOPs, detailing the names of each team member and their level of qualification.

The pharmacy did not have a written procedure to help pharmacy team members manage near miss errors they made while they dispensed medicines. The pharmacy had some records of errors being made. But the latest record was from February 2022. Pharmacy team members knew errors had been made since that had not been recorded. They explained they discussed errors when they were made. And sometimes they made changes to help prevent errors happening again. One example had been separating look-alike and sound-alike medicines escitalopram and enalapril on the shelves to help prevent the incorrect medicine being selected. Team members explained it was the pharmacist's responsibility to record near miss errors. The records that were available contained little or no information about why mistakes had been made. Or the changes team members had made to prevent them happening again. The pharmacy did not analyse the data collected for patterns. This meant team members might miss out on opportunities to learn and make improvements to the pharmacy's services. The pharmacy had a written procedure in place for managing and recording dispensing errors, which were errors identified after the person had received their medicines. But during the inspection, pharmacy team members could not find the records they had made of their errors. So, the quality of their recording could not be assessed. Pharmacy team members, including the responsible pharmacist, did not know how to record and report a dispensing error according to the pharmacy's processes.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It collected feedback from people verbally. The pharmacy did not have any records of any feedback received. Team members gave some examples of adjusting people's delivery times following feedback, to help make sure they were at home when the pharmacy delivered their medicines.

The pharmacy had up-to-date professional indemnity insurance in place. It maintained a responsible pharmacist record electronically, which was complete and up to date. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. These were audited against the physical stock quantity approximately monthly, including methadone. The inspector checked the running balances against the physical stock for three products. And these were correct. The

pharmacy kept private prescription and emergency supply records. And these records were complete. During the inspection, pharmacy team members could not find the pharmacy's register of CDs returned by people for destruction. This was discussed, and they gave their assurances that they had a register and that they would locate it as soon as possible.

The pharmacy kept some sensitive information and materials in restricted areas, but there was a risk of unauthorised access to people's names and addresses on prescription bags, by people using the pharmacy. The pharmacy collected confidential waste in dedicated baskets. They used a shredder at the adjoining GP surgery to destroy their confidential waste. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information.

A pharmacy team member gave some examples of symptoms that would raise their concerns about vulnerable children and adults. They explained how they would refer to the pharmacist. The pharmacy had a documented procedure for dealing with concerns about children and vulnerable adults. And team members said they would use the internet to find local safeguarding to report a concern. Some pharmacy team members had completed training on safeguarding in 2021. But some other, newer members of the team had not completed any training.

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 some appropriate training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they sometimes make effective changes to improve their environment and the way they work.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist who worked at the pharmacy regularly, two dispensers, a trainee dispenser, and a delivery driver. And they managed the workload well during the inspection. Pharmacy team members completed training ad hoc by reading various materials and discussing topics suggested by the superintendent pharmacist (SI). Pharmacy team members could not give any examples of any training they had completed recently. The pharmacy did not have an appraisal or performance review process for team members. Team members explained they would raise any learning needs informally with the pharmacist or SI, who would teach them or signpost them to appropriate resources.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. Following a discussion where team members had identified areas for improvement, the pharmacy had changed the way they planned and organised the preparation of multi-compartment compliance packs. And this was to help prevent delays ordering prescriptions for packs and to ensure that packs were prepared on time for delivery to people. Pharmacy team members explained they would raise professional concerns with the pharmacist or SI. They felt comfortable raising concerns. And confident that concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy, and team members were unsure about how to raise concerns anonymously. This was discussed, including where team members could raise their concerns outside their organisation, such as the GPhC or the NHS.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and properly maintained. It provides a suitable space for the services provided. The pharmacy has an adequately sized room where people can speak to pharmacy team members privately. But the room is somewhat untidy and cluttered, which impacts on the pharmacy's overall professional appearance.

Inspector's evidence

The pharmacy was generally clean and well maintained. It was tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. It mostly kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. There was a sink in the room. The sink was dirty and appeared to have not been used or cleaned for some time. The desk in the consultation room was untidy and was cluttered with various items of paperwork and other equipment. This detracted from the pharmacy's overall professional appearance.

The pharmacy had a clean, well-maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. The pharmacy's professional areas were well defined by the layout and were well signposted from the retail area. Pharmacy team members prevented unauthorised access to the restricted areas of the pharmacy.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy mostly stores and manages its medicines as it should. But it doesn't adequately protect all its medicines from unauthorised access. The pharmacy's services are easily accessible for people. And it mostly manages its services safely and effectively. But some team members have gaps in their knowledge relating to risks associated with some higher-risk medicines. So, there is reliance on the pharmacist to make sure these people receive appropriate care.

Inspector's evidence

The pharmacy had ramped access from the street. Pharmacy team members explained how they would support people who may have difficulty accessing the pharmacy's services. They explained how they would communicate in writing or use hand signals and visual aids to communicate with people with a hearing impairment. And provide large-print labels to help people with a visual impairment. Pharmacy team members were also able to speak several languages spoken locally, including Urdu and Punjabi as well as English. They explained they had also used an online translation tool to help communicate with people, often who spoke eastern European languages, such as Polish.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a pregnancy prevention programme. But they did not check if a person was taking effective, long-term contraception to help them reduce the risks of becoming pregnant while taking valproate. Other pharmacy team members were unsure of their responsibilities in managing people's risks of taking valproate. They were aware of having to provide a warning card to people when dispensing the medicine, but they did not know why. Pharmacy team members had not been provided with any training about valproate or how to help people manage the risks of taking the medicine. The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to some of the packs available to see in the pharmacy, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. But team members did not provide descriptions of medicines with all packs. The team members available during the inspection did not know why some packs were provided with descriptions and some weren't. The pharmacy provided people with patient information leaflets about their medicines each month. It only provided leaflets to people when their medicines were newly prescribed. 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 where they were placed in the packs. And they also documented this information on their electronic patient medication record (PMR).

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. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered medicines to people. It recorded the deliveries made. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves in the

dispensary, but some medicines awaiting delivery to people's home were not stored securely away from areas that people using the pharmacy could access. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the fridges where medicines were stored each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months. And up-to-date records were seen. They highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items at the beginning of their month of expiry. Some boxes were found on the pharmacy's shelves that contained mixed batches of medicines. These were medicines that displayed a batch number and expiry date that did not match the details printed on the outer container. This meant there was a risk of people dispensing these medicines after they expired and before the box was removed from the shelves. And a risk these medicines would not be identified in the event of a manufacturer's recall.

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

Summary findings

The pharmacy has some of the necessary equipment available to provide its services safely. But it does not use suitable measures to pour liquids. So, there is a risk that people may receive the incorrect quantity of their medicines. And it does not keep these measures clean. The pharmacy manages the rest of its equipment adequately, and in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had two plastic measures available. Pharmacy team members used one measure for medicine's preparation. And one measure to prepare substance misuse medicines. The measures were not crown stamped, or marked with any British standard, CE, or ISO marking. This meant there was no evidence of calibration to confirm the accuracy of their measurements. One measure did not have any graduations below 5ml. When questioned, a dispenser said team members would use a plastic oral medicines syringe to measure a quantity less than 5ml. The measures were dirty. During the inspection, one contained residues of medicines that had been previously dispensed. And the pharmacy did not have equipment, such as brushes to be able to easily clean the measures.

The pharmacy had other 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. It had access to a shredder to destroy its confidential waste. It kept its computer terminals in the secure areas of the pharmacy, away from public view. And these were password protected. The pharmacy restricted access to its equipment.

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.