General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Carleton-In-Craven Pharmacy, Old Cobblers Cottage, West Road, Carleton-In-Craven, SKIPTON, North Yorkshire, BD23 3DT

Pharmacy reference: 1113486

Type of pharmacy: Community

Date of inspection: 06/03/2020

Pharmacy context

This pharmacy is in a small village near Skipton. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides palliative care medicines. And the supervised methadone consumption 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	1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services.
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 reviews and manages the impact of increased workload. The pharmacy introduces different ways of working for the team members and provides more computers to help them deliver safe and efficient 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 team generally identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have 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 discuss the errors and they take the action needed to help prevent similar errors happening again. The pharmacy has written procedures that the pharmacy team follows. But the procedures have not been recently reviewed. This means there is a risk that team members may not be following up-to-date procedures.

Inspector's evidence

The pharmacy had a range of 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. Most team members had read the SOPs and signed the SOPs signature sheets to show that they understood and would follow the SOPs. There was no evidence such as the signed signature sheets to show two team members in post for several months had read the SOPs. The SOPs had review dates of 01 October 2017 but there was no evidence to show that the SOPs had been reviewed. 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 near miss errors. But the last entry was on 16 January 2020. A sample of the near miss records that had been completed found that the team recorded details of what had been prescribed and dispensed to spot patterns. And team members recorded the actions they had taken to prevent the error happening again. The actions varied such as to slow down when dispensing and to correctly label the prescription. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. All team members were informed of the dispensing incident so they could learn from it. And the pharmacist recorded the error on the person's electronic medication record (PMR). So, all the team were aware of the error and to prevent the same error happening to the same person. The pharmacist asked the team to highlight on prescriptions the formulation of medicines that were often involved with errors. For example, prescriptions for ramipril tablets and capsules.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information 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. Following complaints from people about getting through to the team on the telephone the pharmacy updated the telephone system to provide a queuing system. The update also allowed team members to transfer calls from one telephone to another. So, the main telephone system was free for people to call the pharmacy. This also ensured that the team were not breaking off from tasks such as dispensing to answer the telephone. The Superintendent Pharmacist had noticed that team members breaking off to answer the telephone was a common cause of near miss errors. The pharmacy had also trained the delivery drivers to answer the telephone when they were in the pharmacy. And to

take notes of any queries to pass on to the pharmacist or other team members for them to respond to the person.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy did not regularly check all the CD stock against the balance in the register to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. 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 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 team separated confidential waste for shredding onsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The delivery drivers reported to the pharmacy team any concerns they had about people they delivered medicines to. When the pharmacists wanted to speak to a person who was housebound, they asked the delivery drivers if they knew of any communication problems the person had. So, the pharmacist could decide the best way to communicate with the person.

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 reviews and manages the impact of increased workload. The pharmacy introduces different ways of working for the team members and provides more computers to help them deliver safe and efficient pharmacy services. The pharmacy offers team members some opportunities to complete more training. And it provides feedback to team members on their performance. The team members support each other in their day-to-day work. And they usually share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. The team members introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

The Superintendent Pharmacist and two regular pharmacists covered most of the opening hours. The pharmacy team consisted of three part-time pharmacy technicians, three part-time qualified dispensers and three delivery drivers. At the time of the inspection the Superintendent Pharmacist, the two regular pharmacists, one of the pharmacy technicians, one of the dispensers and the three delivery drivers were on duty. The drivers had received training from the pharmacy on a basic understanding of medicines. So, they could pass on queries from people they delivered to back to the team to respond to the person.

Over the last few months the pharmacy had seen an increase in the volume of dispensing. To manage the increased workload the Superintendent Pharmacist was planning a staff rota. This ensured the team members kept their focus on the tasks. And ensured they had a range of skills, so they could support the pharmacy services in times of absence. The part-time pharmacists had increased their hours to support the pharmacy. The pharmacy had recently recruited a new member of the team to help with administration work and answering the telephone. This was currently done by one of the delivery drivers. So, the new team member would ensure the driver was free to help with deliveries. The pharmacy was installing additional computers to help the team manage the workload.

The pharmacy provided some additional training for the team. The pharmacy technicians shared the learning they received from CPPE events with the team, such as Sepsis. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The Superintendent Pharmacist held meetings with the team when key pieces of information needed to be shared. Team members could suggest changes to processes or new ideas of working. As the pharmacy got busier the team noticed an increase in workload. So, they met to discuss how to manage this. And identified that some tasks were no longer needed as the process had changed. The pharmacy had a whistleblowing policy. The pharmacy did not set targets for its pharmacy services. The pharmacy team offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. The pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. 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 sound proof 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. And they manage the pharmacy services well. When team members identify issues that may affect the safe and effective delivery of services, they proactively act to address them. The pharmacy team members keep records of prescription requests and deliveries. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines well.

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 displayed the posters from HM Government and the NHS about the Coronavirus.

The pharmacy provided multi-compartment compliance packs to help around 170 people take their medicines. People received monthly or weekly supplies depending on their needs. One of the regular pharmacists managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team had a list of people who received compliance packs. And it used the list to record who in the team had dispensed and checked the packs. The team received prescriptions in advance of supply. So, the team had 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, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team picked the medicines to go into the packs before dispensing. So, they had all the medication available at the time of dispensing. The team used a section to the rear of the dispensary to dispense the medication. Team members were asked to not disturb colleagues when they were dispensing the medicines in to the packs. The team recorded the descriptions of the products within the packs. But the team did not always supply the manufacturer’s patient information leaflets. The team provided the service to a person who had medicines with doses up to eight times a day. To support the person the team provided two packs clearly labelled with each dose time. And provided a sheet with the packs that listed the eight time slots. The team found one person struggled to use the packs so was not taking their medicines. The team provided the person with a Pivotell automatic pill dispenser. The team filled each section with all the doses of medicines due and set the timer. The team found that the person was still not taking their medicines and discovered the Pivotell was being incorrectly stored which affected the timer and release mechanism. So, the team attached a note to the Pivotell advising how to store the Pivotell. And the person was able to take their medicines. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. And kept the discharge summary to refer to when queries arose. The team received forms from the GP teams about changes to people’s medication. The team had dedicated folders containing clear wallets holding each person’s medication list and other documents such as the forms from the GP requesting medicine changes. The delivery drivers spent time with people receiving the packs for the first time explaining how to use the packs.

The pharmacy provided original packs of medicines to five care homes. The pharmacy technician

managed the service with support from others in the team. The pharmacy kept a list of tasks to be completed for each stage of processing the prescriptions for the care homes. The list included ordering and collecting prescriptions and labelling the medicines. The care homes teams ordered the prescriptions in advance of supply. And sent a list of each person's medicine to the pharmacy team. This indicated the medicines ordered, medicines not ordered but the person was still taking and any discontinued medicines. The pharmacy team sent the medicines a few days before the next cycle started. This allowed time for the care home team to check the supply and chase up missing medicines.

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 team members provided a repeat prescription ordering service. The team usually ordered the prescriptions a week before supply. This gave the team time to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of the requests and regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The local GP teams had stopped pharmacies ordering prescriptions on behalf of people. The team members identified that some people may struggle to order their prescriptions using the methods provided by the GP teams. So, they developed a form for people to complete indicating whether they were able to use any of the prescription ordering methods offered by the GP team. The person signed the form and the team sent this to the GP teams with a request for the pharmacy to order the prescriptions on behalf of the person. The pharmacy team had completed checks to identify people who met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team divided the processing of prescriptions into repeat prescriptions and delivery 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 team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used controlled drugs (CD) stickers 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 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 record also included the date and time of the delivery. The team used a form to get consent from people who wanted the option of the delivery being made to a neighbour or their place of work. The form also had a statement requesting the person to inform the pharmacy team if the person's circumstances changed or they no longer wanted to use this service. The person signed and dated the form.

The pharmacy team checked the expiry dates on stock. And kept a record of this. 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 Sytron liquid with three months use once opened had a date of opening of 27 January 2020 recorded. The team recorded fridge temperatures each day. A

sample looked at found they were within the correct range. The delivery drivers had cool boxes for holding fridge lines during transportation. 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 equipment to meet the requirements of the Falsified Medicines Directive (FMD). But it was waiting for a computer upgrade to enable the team to scan FMD packs. 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 met

Summary findings

The pharmacy has the equipment it needs to provide safe services and 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 two fridges to store medicines kept at these temperatures. The team used one fridge for medicine stock and used the other fridge for stock and completed prescriptions awaiting supply. 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 pharmacy stored completed prescriptions away from public view. And it 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.