General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ovenden Pharmacy, Beechwood Medical Centre, 60A Keighley Road, HALIFAX, West Yorkshire, HX2 8AL

Pharmacy reference: 1115886

Type of pharmacy: Community

Date of inspection: 21/01/2020

Pharmacy context

This is a community pharmacy next to a GP surgery in the town of Halifax, West Yorkshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. It is open seven days a week. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service (NMS) and medicines use reviews (MURs). The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own homes and some local care homes. And it provides a home delivery 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	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 the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members know when to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss any mistakes that they make when dispensing. But they do not keep records of these mistakes. And so, they may miss out on the opportunity to learn from them and reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had a small retail area. It could be accessed from the front entrance door and directly from the surgery waiting room. The dispensary was located behind a small pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was set back far enough from the pharmacy counter to allow the team members discuss confidential matters without being overheard by people in the retail area.

The pharmacy had a set of up-to-date written standard operating instructions (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. They were prepared in 2016 and were reviewed each year. The last review had been completed in February 2019. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role.

The pharmacist highlighted any near miss errors made by the team when dispensing. There was a paper near miss log that the team could use to record the details of near miss errors. There were sections to record the date and time the error happened, the type of error and any factors that may have contributed to the error. The team had regularly recorded the details of any near miss errors over the last few years. But the log had been rarely used in the last nine months. Only three near miss errors had been recorded since March 2019. The team members said that their main reason for many of the most recent errors was because of a lack of concentration or rushing. But they did not investigate these reasons any further. The pharmacist explained he discussed any near misses with the team members that were present at the time. And they discussed ways of improving their practice to reduce the risk of similar errors happening. A team member had recently changed the way she dispensed by ticking the name, strength and quantity of each medicine on the packaging and prescription. This helped her slow down the dispensing process and improve her accuracy. The pharmacy had a basic process to handle dispensing incidents that had reached the patient. But the pharmacy did not keep any records for future reference. And the team were unable to recall any recent incidents that had happened.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn’t do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure in place. And it was displayed on a poster in the retail area. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. But the team members were not aware of the results of any recent surveys. And could not provide any examples of any improvement measures they had taken following any feedback.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. It kept controlled drugs (CDs) registers. And they were completed correctly. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members had not undertaken any training on General Data Protection Regulation (GDPR). But they were aware of the need to keep people's personal information confidential. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The responsible pharmacist and a pharmacy technician had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had an SOP on child protection and safeguarding vulnerable adults. The SOPs had sections to document the contact numbers of the local safeguarding teams. But they were left blank. And so, the team members may not know who to report any concerns to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy provides its team members that are enrolled on a training course, with a protected training time to help them work through their course without distractions.

Inspector's evidence

The responsible pharmacist was a one of three regular pharmacists that the pharmacy employed. He was supported by a full-time trainee pharmacy technician, a full-time and a part-time NVQ level three qualified pharmacy technician, a full-time NVQ level two qualified pharmacy assistant, a full-time counter assistant and a locum pharmacist. The responsible pharmacist worked every Sunday and between 7am and 2pm from Monday to Thursday. Two other employed pharmacists covered the remaining hours. The team members said they felt they had enough staff to manage the workload. The pharmacy owner organised double pharmacist cover to help the pharmacy if it ever fell behind with its dispensing workload. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy encouraged its team members to undertake some basic training to update and refresh their knowledge and skills. The team members who were not enrolled on a training course did not receive any time to train during the working day. But when the pharmacy was quiet, they took some time to read material that was received by the pharmacy by external training providers. The trainee pharmacy technician was provided with four hours of protected training time to work through her training course. She explained she was well supported by the pharmacy’s owner and her colleagues. For example, she found a calculations module challenging. She discussed this with the pharmacy’s owner. And she was given a one-to-one training session with one of the regular pharmacists to help her understand and complete the module.

The pharmacy had an appraisal process for its team members. The appraisals took place every three to six months. And they were in the form of a one-to-one conversation between the team member and a pharmacy assistant who was the pharmacy’s manager. The team members were asked which aspects of their roles they felt they were excelling in and the manager set them goals to meet by the next appraisal. The team members aimed to hold a team meeting every Thursday as this was the day that all the team members were working. The meetings were an opportunity for the team members to discuss any issues and ways in which they could improve the quality of the service the pharmacy was providing to people.

The team members felt comfortable to raise professional concerns with the pharmacy manager or the

pharmacy's owner. The pharmacy had a whistleblowing policy in place. So, the team members could raise any professional concerns anonymously. They were set various targets to achieve. These included the number of prescription items they dispensed, and the number of service consultations completed. The team members felt the targets were mostly achievable. The targets did not affect their ability to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were small. It was clean and professional in appearance. There was signage identifying the premises as a pharmacy on the outside of the building and next to the surgery waiting room. The dispensary was particularly small for the services provided. There were many boxes containing medicinal stock in the walkways. But the team members managed the bench space well.

There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a staff toilet with a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. It regularly checks the expiry dates of its stock. But it doesn't keep records of the checks. And so, there is no audit trail of the process in place.

Inspector's evidence

The pharmacy had level access from the surgery car park and the surgery waiting room. And so, it was easy for people with wheelchairs or prams to enter the premises. There were some disabled car parking spaces in the surgery car park. The pharmacy advertised its services and opening hours around the retail area. The opening hours were not advertised on the outside of the premises. And so, people could not see them when they pharmacy was closed. It used a small section of the retail area to promote healthy living advice. At the time of the inspection, the area was displaying information on smoking cessation, winter health and alcohol consumption. The team had access to the internet to direct people to other healthcare services.

The team members regularly used alert stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. The pharmacy did not have a system to highlight prescriptions for a CD that was not required to be stored in the CD cabinet. And so, the team members did not always check the date of issue of the prescription to prevent them from handing out any CDs to people after their prescription had expired. 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 pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes and some local care homes. The pharmacy supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication.
They dispensed the packs on benches that were at the rear of the dispensary and furthest away from the retail area. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents related to each person on the service in separate wallets. The documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. The packs were supplied with dispensing labels which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour and shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

People living in care homes were provided with medication administration charts.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members used green ‘Speak to Pharmacist’ stickers which were attached to people’s prescriptions as a reminder to discuss the person's treatment when handing out the medicine. The pharmacist explained he did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. But the team did not check if any of its regular patients were prescribed sodium valproate.

Pharmacy medicines were stored behind the pharmacy counter. Which prevented people from self-selecting the medicines. Every few weeks, the team members checked the expiry dates of its medicines to make sure none had expired. But no records of the checks were kept. One out-of-date medicine was found after a random check of around thirty medicines. The team members recorded the date liquid medicines were opened on the pack to check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had not received training on how to follow the directive, but it had the correct type of scanners and software installed. Drug alerts were received via email to the pharmacy and actioned. The team did not keep a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were some cylinders which were only used for dispensing methadone. But these cylinders were not clearly marked. And so, they may have been used incorrectly. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. 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 seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people 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.