General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pickfords Pharmacy, 125-127 Wath Road, MEXBOROUGH, South Yorkshire, S64 9RB

Pharmacy reference: 1116066

Type of pharmacy: Community

Date of inspection: 15/02/2023

Pharmacy context

This is a community pharmacy in a residential area in the South Yorkshire town of Mexborough. The pharmacy's main services include selling over-the-counter medicines and dispensing NHS prescriptions. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers 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 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 not all met	4.3	Standard not met	The pharmacy does not always store and manage its medicines as it should and in accordance with the manufacturer's instructions. And it does not have robust processes including for date checking to ensure medicines remain fit for purpose and safe to supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy mostly identifies and manages the risks associated with its services. It keeps people's personal information secure. And it generally keeps the records it must by law. Pharmacy team members understand how to recognise, and report concerns to protect the wellbeing of vulnerable people. They are confident in managing feedback about the pharmacy or its services. And they engage in conversations designed to reduce risk following mistakes. But not all team members confirm they have read and understood the pharmacy's procedures. This may lead to some variation in the way team members work.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The SOPs were due for review. The company's training recruitment and communications manager (TRCM) was visiting the pharmacy on the day of the inspection and confirmed this review process had begun. Most members of the current team had transferred to the pharmacy from others within the company. And they demonstrated familiarity with the SOPs. But only one team member had signed the SOPs to confirm they had read and understood them. Team members were observed following dispensing SOPs when completing tasks in the dispensary.

The pharmacy had tools to support its team members in recording mistakes made and found during the dispensing process, known as near misses. Recent near miss records showed consistent recording following these types of mistakes. The team demonstrated how they acted on near misses by separating similar sounding medicines and those in similar packaging on the dispensary shelves. But they did not regularly engage in formal reviews designed to share learning following these types of events. The RP provided a clear explanation of how they would act to resolve and report a mistake identified after a medicine had been supplied to a person, known as a dispensing incident. The team were familiar with the need to report incidents internally via an electronic reporting form. But there were no local copies of incident forms available for inspection. The TRCM confirmed that evidence of reporting could be obtained from the company's regional office. And the team could identify actions taken to reduce the risk of similar mistakes occurring following incidents. For example, by applying flash notes on people's medication records.

The pharmacy had a complaints procedure. And its team members understood how to manage concerns. This process included establishing the person's expectations and local resolution of their concern whenever possible. But it did not have copies of its practice leaflet available for people to take. This leaflet was intended to provide people with further information about the pharmacy including how they could provide feedback or raise a concern. The pharmacy had safeguarding procedures in place, and its team members understood the importance of acting on safeguarding concerns. They had received appropriate training to support them in recognising and raising these types of concerns. Team members were aware of both the 'Ask for ANI' and 'Safe Space' safety initiatives, designed to provide people suffering domestic abuse.

The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct

details of the RP on duty. The RP record was generally kept in accordance with requirements but there were some gaps where pharmacists had not signed out of the record. The controlled drug (CD) register was maintained in accordance with legal requirements. The pharmacy maintained running balances in the CD register but full physical balance audits against the register were infrequent. Recent efforts to improve the frequency of balance checks were seen. But a large overage of a liquid medicine identified by the team in early February had yet to be fully investigated or reported. A discussion highlighted the priority for doing this. And confirmation from the deputy SI following the inspection was received to confirm this had been done, and the cause of the overage found and rectified. A random balance check conformed to the balance recorded in the register. The pharmacy kept records associated with private prescriptions and specials medicines in good order. The pharmacy had procedures in place to support the safe handling of confidential patient information. It held personal identifiable information on computers and within areas of the pharmacy only accessible to staff. Confidential waste was disposed of securely.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people working to provide its services effectively. And it has systems to support the learning needs of its team members. Pharmacy team members engage in conversations relating to risk management and safety. And they understand how to raise and escalate concerns at work.

Inspector's evidence

The RP was a locum pharmacist who had not worked at the pharmacy before. Team members were observed working well with them to manage the pharmacy services. The team had been working with locum pharmacists for some time and was recruiting for a permanent regular pharmacist. The team consisted of four qualified dispensers and a delivery driver. One dispenser had been acting pharmacy manager until relinquishing this role very recently. A new non-pharmacist manager had been recruited and was due to commence their role shortly. One of the dispensers was a member of the relief team and had been supporting the pharmacy on a regular basis in recent weeks. The pharmacy had seen some changes to its staffing within the last couple of years. The team discussed some pressures on its workload. This was a combination of having no regular pharmacist, some staffing changes, and some challenges with its workload due to receiving prescriptions late or needing to query or request new prescriptions from a surgery. Workload was seen to be up to date and the team acted with care by greeting people as they presented at the medicine counter. The pharmacy was preparing for additional changes as it was due to start sending some of its workload to the company's offsite dispensing hub.

Pharmacy team members had access to ongoing learning to support them in their roles. This included some virtual learning sessions and training associated with the NHS Pharmacy Quality Scheme. A team member described engaging in conversations about how they were settling into the team during the first few months of working at the pharmacy. Pharmacy team members showed awareness of an expectation to promote and deliver the pharmacy's services safely and efficiently. The RP reported that specific targets associated with services had not been discussed with them prior to working at the pharmacy. The pharmacy had a whistleblowing policy and its team members understood how to raise and escalate concerns at work. The TRCM was visiting the pharmacy to support the team in preparing an evidence portfolio associated with the PQS. Team members held some discussions to share information about workload and risk management. But they did not generally record the outcomes of these discussions. A team member provided an example of the type of ongoing discussions taking place such as highlighting similar looking packaging to each other when unpacking the medicine order.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are maintained to the standards required. They are clean and provide a suitable atmosphere for delivering pharmacy services. People can speak to a member of the pharmacy team in private consultation rooms designed to protect their confidentiality.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. The team provided details of recent maintenance work carried out and confirmed that the owners dealt with maintenance issues in a timely manner. The pharmacy was appropriately clean and working areas were tidy. Lighting and ventilation were appropriate throughout the premises. Pharmacy team members had access to handwashing facilities including antibacterial hand wash at sinks. The public area was relatively open plan and stocked health related items, gifts, and toiletries. Two private consultation areas led off the public area. One room provided access to a hatch leading to the dispensary and the other room provided a small space for people to sit down with a team member when having a private discussion.

The premises were spread over two floors with most tasks taking place on the ground-floor level. The dispensary was a suitable size for the workload carried out. Off the dispensary was some staff facilities. A door off the public area led to stock rooms and the first-floor level. The first-floor level provided protected space for dispensing tasks associated with care home and multi-compartment compliance pack services. There was also additional storage space and offices. The first-floor level of the premises also provided team members with kitchen and additional toilet facilities.

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

Summary findings

The pharmacy does not consider all of the risks associated with managing its medicines safely. This includes specific risks associated with removing medicines from their original packaging. And its team members do not always follow date checking processes designed to ensure medicines remain safe to supply to people. This increases the risk of a mistake occurring during the dispensing process. The pharmacy's services are accessible to people and people receive information to support them in taking their medicines safely.

Inspector's evidence

The pharmacy was accessible by a ramp and steps from street level. It advertised its opening hours and an additional notice on the door informed people of an upcoming change to access times for its substance misuse services. This was due to a forthcoming change to the pharmacy's operating hours. There was a range of health displays and information leaflets available to people. Pharmacy team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them in screened units to the side of the medicine counter. The pharmacy team was aware of most aspects of the valproate Pregnancy Prevention Programme (PPP). It did not currently supply valproate to people in the at-risk group. The RP discussed how he would manage a prescription for valproate for a person within this group. A discussion highlighted the need to detach patient cards during the dispensing process to ensure these were readily available to supply directly to a person in the at-risk group. Team members explained how they verbally counselled people on the safe use and side effects of some higher-risk medicines. But most checks associated with counselling for these higher risk medicines was verbal and was not recorded on the patient medication record (PMR) to support continual care.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. And team members brought prescriptions belonging to people waiting in the public area, to the direct attention of the RP. The pharmacy retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. It kept an audit trail of each person it delivered medicine to by using an electronic delivery system which included the use of barcode technology. This helped the team to manage any queries associated with the medicine delivery service.

The pharmacy used individual patient record sheets to support it in supplying medicines in multi-compartment compliance packs. And changes to medicine regimes and queries were recorded clearly on a correspondence record held with each person's record sheet. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. It assembled some compliance packs ahead of it receiving the prescriptions. The process followed by team members considered the risks involved in this practice. Team members used up-to-date backing sheets to pick the medicines. And this sheet was cross checked against the patient medication record (PMR). Accuracy checks took place following the receipt of the prescription. The team retained full supportive information, including

the original packs used to fill the compliance packs to support the accuracy check. There was a clear process for matching the backing sheet used to pick the medicines with the prescription. But no risk assessment of the process had been undertaken. And the practice was not in accordance with the pharmacy's SOPs. This limited assurances that team members were working in the safest and most effective way. The pharmacy supplied some medicines to people residing in care homes and assisted living accommodation. The responsibility for ordering these prescriptions was on care managers. The pharmacy liaised with care managers and surgeries if it had prescribing queries or medicine concerns. It supplied Medication Administration Records (MARs) when supplying these medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. But it did not always store its medicines in accordance with manufacturer's instructions. For example, some were stored in amber bottles without full information of the medicine inside on the label such as batch number and expiry date. Other medicines were found to be removed from their protective foil strips but stored within the original box. This meant they were subject to environmental factors such as moisture in the air. The pharmacy was reintroducing a date checking matrix and team members were observed checking expiry dates during the dispensing process. But a random check of stock medicines in the dispensary found some out-of-date medicines. And team members did not always annotate liquid medicines with shortened shelf-lives once opened at the time of opening the bottles. This meant that it was not always possible to identify if a liquid medicine remained safe and fit to supply. The pharmacy stored medicines subject to safe custody arrangements appropriately in secure cabinets. Medicines inside these cabinets were held in an orderly manner. The pharmacy had two fridges for storing medicines that required refrigeration. And the team checked the operating temperature of both fridges each working day and recorded these. The records showed that the fridges were operating between two and eight degrees Celsius. One fridge had been operating at the top end of this temperature range for several days. On the day of inspection this fridge was operating at ten degrees Celsius. Additional checks on the fridge found that a team member had accidentally turned the temperature controls in the wrong direction. This was quickly resolved. The pharmacy had medicine waste bins and CD denaturing kits available. The team received medicine alerts by email and provided evidence of the alerts it had recently actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members generally have access to the equipment they require to provide the pharmacy's services safely. And they use this equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date reference resources available. These included online access to the most recent version of the British National Formulary (BNF). Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computers were password protected and all permanent members of the team had their own NHS smartcard. Information displayed on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines in a protected area. This meant that information on bag labels could not be seen by unauthorised personnel. The pharmacy had a range of equipment available to support the delivery of its services. This included CE marked glass measures for measuring liquid medicines and clean equipment for counting tablets and capsules. Team members used separate equipment for measuring and counting higher risk medicines.

The pharmacy provided the NHS Hypertension Case-Findings Service. It had a blood pressure machine within its consultation room, but this was described as being used for ad-hoc screening purposes only. The team explained how it obtained another machine, compliant with the requirements of the NHS service specification for the NHS service. But this machine was not immediately available onsite, meaning there may be some delay to people accessing the service. Pharmacy team members could request an ambulatory blood pressure monitor from the pharmacy's regional office if required. A discussion took place about the need to ensure any monitors used for the service were listed on the approved list as indicated in the 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.