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: 14/09/2023

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 also provides the NHS New Medicine Service (NMS), NHS blood pressure check service, substance misuse services and the NHS seasonal flu vaccination service. 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 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 effectively identifies and manages the risks with providing its services. It generally keeps the records it needs to by law in good order. And it keeps people's personal information secure. Pharmacy team members know how to respond to the feedback they receive about the pharmacy's services. They understand how to raise a concern about a vulnerable person to help keep them safe from harm. And they engage in conversations and learning designed to reduce risk following the mistakes they make during the dispensing process.

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. Team members had signed to confirm they had read and understood the SOPs. A contents page helped to identify when each SOP was due for review. The pharmacy had recently received some SOPs which had been identified for review this year. The pharmacy manager explained team members would receive time and support at work to complete learning for the updated SOPs. Team members were observed following dispensing SOPs when completing tasks in the dispensary. And they had a good awareness of their own roles and responsibilities. A team member discussed the tasks that could not be completed if the RP took absence from the pharmacy.

The pharmacy had tools to support its team members in recording mistakes made and found during the dispensing process, known as near misses. Near miss records showed consistent recording following these types of mistakes. Comments within the record showed how team members reflected on and applied action to reduce risk following their mistakes. The team provided examples of actions taken to reduce risk. This included separating similar sounding medicines and those in similar packaging on the dispensary shelves. 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 and provided evidence of incident reporting. Investigation notes included identifying the root cause of an incident and the action taken to reduce the risk of a similar mistake occurring.

The pharmacy had current indemnity insurance. The RP notice was updated as the inspection began to reflect the correct details of the RP on duty. The RP record was generally completed in full; some records did not have the sign-out time of the RP. The CD register was kept in accordance with legal requirements. The pharmacy maintained running balances in the CD register and full balance checks of the register against physical stock took place regularly. The pharmacy kept records associated with private prescriptions in good order. It had procedures to support the safe handling of confidential information and team members had completed data security training. The pharmacy held personal identifiable information on computers and within staff-only areas of the pharmacy. Confidential waste was disposed of securely.

The pharmacy had a complaints procedure. But it did not advertise how people could provide feedback or raise a concern. Team members knew how to manage and escalate feedback. They provided

examples of establishing people's expectations and trying to resolve a concern locally in the first instance. The pharmacy had safeguarding procedures. Some team members had completed safeguarding learning, the RP on duty had completed level two learning and had provided evidence of this learning prior to receiving a booking for a shift from the pharmacy. Team members identified how they would recognise and report safeguarding concerns. They were aware of both the 'Ask for ANI' and 'Safe Space' safety initiatives, designed to support people experiencing domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people who work together well to deliver its services. Pharmacy team members engage in some ongoing learning relevant to their role. And they show how they use shared learning opportunities to reduce risk. Team members are confident in providing feedback at work and they know how to raise professional concerns.

Inspector's evidence

The pharmacy did not have a regular pharmacist. The RP on duty was a locum pharmacist and had a good understanding of the pharmacy's procedures. A trainee dispenser had taken over the role of pharmacy manager around five months ago. The pharmacy also employed three qualified dispensers and a delivery driver. A temporary driver from another of the company's pharmacies was providing the delivery service on the day of inspection. Team members were observed working together well throughout the inspection. One team member worked part-time with some flexibility in their role to help cover when a full-time team member was absent.

Team members completed some ongoing learning to support them in their roles. Several team members had recently completed vaccination training to support in providing the seasonal flu vaccination service. The RP provided examples of how they shared their own learning with the pharmacy team. This had recently included learning following circulation of a case study designed to highlight and reduce risk when dispensing a higher-risk medicine to children. The team had acted to reduce risk by implementing warning prompts on the dispensary shelves following this learning being shared. The manager confirmed they felt supported in their role and had recently discussed the need to have some dedicated training time at work now they had settled into their management role, and this had been agreed.

Team members engaged in daily briefings about workload and pharmacy services. The manager fed back information from weekly manager's meetings. This included information to support patient safety and adherence to procedures. This feedback was written down which made it easy for team members to refer to. The pharmacy had a whistleblowing policy. Team members knew how to raise concerns at work, and they understood how to escalate a concern if needed. They provided examples of positive changes to organisation in recent months, and it was clear that workload pressure had reduced since the last inspection in February 2023. The pharmacy had some targets aligned to the services it provided. Team members were positive when discussing the targets and the RP discussed how they applied their professional judgment when providing the pharmacy's services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe, clean, and secure. It provides a suitable environment for delivering healthcare services. It offers quiet, protected spaces for people who wish to speak to a member of the pharmacy team in private.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. The team knew how to report maintenance concerns and there were no current concerns waiting to be managed. The pharmacy was clean and tidy. Lighting and ventilation were adequate throughout the premises. Pharmacy team members had access to handwashing facilities including antibacterial hand wash at sinks. The public area was open plan and stocked medicines, healthcare products and toiletries. There was a dedicated health promotion zone set up in a quiet corner of the public area with a table and seating provided, people could sit and have a general chat with a team member in this area. 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 staff facilities. A door off the public area led to stock rooms and stairs leading to the first floor. The first floor provided protected space for dispensing tasks associated with the care home and for assembling multi-compartment compliance packs. There was also additional storage space and offices. Team members had access to a kitchen and additional toilet facilities on this level.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from licensed sources. And it stores its medicines safely and securely. Pharmacy team members make regular checks to ensure medicines are safe to supply. They engage people visiting the pharmacy in services designed to support people's health and wellbeing. But people do not always receive written information about their medicines to help them take them safely.

Inspector's evidence

The pharmacy was accessible through a door leading from a ramp and steps from street level. It advertised its opening hours and details of its services, including how people could book a flu vaccination. The public area was open plan and contained plentiful seating for people waiting for their prescriptions or a pharmacy service. There was a range of health displays and information leaflets available to people. Pharmacy team members had a good awareness of other local health services and knew 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 behind the medicine counter and in screened units to the side of the medicine counter. There was a range of tools to support the team in dispensing higher-risk medicines. The RP discussed the requirements of several Pregnancy Prevention Programmes (PPPs). And details of the requirements of the valproate PPP were prominently advertised within the dispensary and within the public area of the pharmacy. Pharmacists counselled people on the safe use and side effects of higher-risk medicines. But they did not routinely record details of these conversations on the patient medication record (PMR) to support continual care. The team recognised how people benefitted from the services they provided. The RP discussed several examples of providing services in a way which put people at ease. For example, ensuring they felt calm when having their blood pressure checked.

Information to support the delivery of pharmacy services was kept in individual service folders which were organised and accessible. This included a New Medicine Service diary to ensure people were contacted by a pharmacist to discuss their new medicines. And information to support the delivery of the NHS seasonal flu vaccination service which the pharmacy was starting shortly. This information included the current service specification, national protocol, and patient group direction (PGD). Pharmacy team members completed a range of audit trails to support them in managing the pharmacy's services. For example, signing the 'dispensed by' and 'checked by' boxes on medicine labels during the dispensing process. The team had effective processes for managing owed medicines and for recording the medicines it delivered. Its workload was well managed with colour coded baskets used to prioritise work and to keep medicines with the correct prescription.

The pharmacy sent most work associated with the supply of multi-compartment compliance packs to one of the company's hub pharmacies. Prescriptions were entered on the PMR system by a team member who checked their entries against individual profile sheets for each person receiving medicines in this way. A pharmacist clinically checked prescriptions and accuracy checked the information entered prior to information being sent to the hub pharmacy. Team members completed an audit trail of this

activity. But this audit trail was only kept for a brief time, meaning it might be more difficult for the team to respond to a query at a later date. The pharmacy had an effective process for locally dispensing items that did not go inside the compliance packs and matching these to compliance packs arriving from the hub. The pharmacy dispensed several compliance packs directly. This was due to complex medicine regimens. For example, six times a day dosing. A sample of locally assembled packs contained full dispensing audit trails. The inspection found an omission of information on the backing sheet of a compliance pack assembled at the pharmacy and waiting to be supplied. This mistake was corrected and entered on to the near miss record to reduce the risk of a similar event occurring. The pharmacy demonstrated how it supplied patient information leaflets (PILs) when dispensing compliance packs locally. But PILs were not routinely supplied with packs coming from the hub pharmacy. The pharmacy provided medication administration records (MARS) when supplying medicines to people living in a local care home. The pharmacy managed most correspondence with the care home or surgery teams through secure email. This meant the pharmacy generally had an audit trail of the queries its team made.

The pharmacy sourced medicines from licensed wholesalers. It stored these neatly and within their original containers. The pharmacy stored its CDs securely. It clearly separated out-of-date CDs and patient returned CDs within one of its cabinets. It kept its cold-chain medicines in two pharmaceutical fridges. Fridge temperature records showed the fridges were working within the required temperature range. The pharmacy had reintroduced a date-checking matrix since the last inspection. This showed regular date checks of all stock taking place with most short-dated medicines clearly identified. Team members were observed checking expiry dates routinely when dispensing medicines. A random check of dispensary stock found one out-of-date medicine. This was brought to the attention of the team and removed for safe destruction. Team members recorded the date of opening on liquid medicines to support them in making checks to ensure the medicine remained safe to supply to people. The pharmacy had medicine waste bins, sharps bins and CD denaturing kits available. The team received medicine alerts by email and provided evidence of the alerts it had recently actioned. The pharmacy manager discussed the action they had taken following a concern about cold-chain medicines following an incident where a fridge had been switched off. They had appropriately contacted medicine manufacturers when managing their concerns. And action had been applied to prevent a similar situation occurring.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And its team members use the equipment with care and in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had current reference resources available. Pharmacy team members also accessed the internet to help resolve queries and to obtain information. The pharmacy protected its computers from unauthorised access by using passwords and NHS smartcards. Information displayed on computer monitors was only visible to authorised personnel. It stored bags of assembled medicines safely in an appropriately screened area between the medicine counter and dispensary. Pharmacy team members used a cordless telephone when speaking to people over the telephone. This allowed them to move with the telephone to maintain confidentiality when talking to people about their medicines.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicine with separate measures identified for use only with a higher-risk liquid medicine. The pharmacy's equipment was regularly checked to ensure it remained fit for purpose. For example, plugs attached to electrical equipment were clearly marked to confirm they were in safe working order. The team was in the process of putting together equipment to support the rollout of the flu vaccination service, this equipment included emergency medicines to treat anaphylactic reactions.

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.