General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: South Kirkby Pharmacy, Churchview Health Centre, Langthwaite Road, South Kirkby, PONTEFRACT, West Yorkshire, WF9 3AP

Pharmacy reference: 1118547

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

This community pharmacy is in a large health centre in the town of South Kirkby. The pharmacy dispenses NHS and private prescriptions. And it provides medication in multi-compartmental compliance packs to help people take their medicines. The pharmacy administers seasonal flu vaccinations. And it delivers medicines to people's homes.

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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy supports new members of the team. And it provides all team members with opportunities to complete more training. The pharmacy provides feedback to team members on their performance. And it encourages team members to identify opportunities to develop their career.
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 its services. And it has written procedures that the team follows. People using the pharmacy have several ways in which they can raise concerns and provide feedback. And the pharmacy has suitable arrangements to protect people's private information. The pharmacy 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 well when errors happen. They learn from each other and they take the action needed to help prevent similar mistakes happening again.

Inspector's evidence

The pharmacy had a range of up-to-date 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. The team had read and signed the SOPs' signature sheets to show they understood and would follow them. 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 errors. And the team member who made the error recorded their own mistake. The form used to record these errors had codes to capture the type of error, the cause and actions taken to prevent the error from happening again. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error and the actions they had taken to prevent the error happening again.

The pharmacy team reported dispensing incidents. And sent the report to head office. The team kept a copy of the report for reference. All the team discussed the dispensing incident, not only the team members involved. And the team completed a root cause analysis (RCA) to capture what caused the error and the actions the team took to prevent the error from happening again. For example, one report captured the supply of a medicine against a prescription for another medicine of the same strength. The reported stated that the error was caused by the team member rushing to complete the prescription. And they had only read the prescribed strength, which was the same for both medicines. The report stated that the two medicines also had similar sounding names. In response to this error the team attached to the shelves holding these items large labels with the name of the medicine written on. The team used the labels as a prompt to double check the medicine selected.

The pharmacy undertook monthly and annual patient safety reviews. The team used the review to help spot patterns and make changes to processes. The accuracy checking technician (ACT) led on this and shared the results with the team. If the pharmacist spotted patterns with errors before the monthly review she would speak to the team and agree actions to prevent similar mistakes. The ACT had used a recent monthly review to remind the team to clearly mark split boxes. And this review reported that a new workflow and the training of more team members on key tasks had enabled the team members to improve the service they provided to people. The pharmacist had placed allopurinol in a labelled basket on the shelf, after being informed of an error with this medicine in another pharmacy.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster and a leaflet providing people with information on how to raise a concern. The pharmacy had a device on the pharmacy counter that had buttons for people to press to rate how the pharmacy team had performed. The pharmacy team also used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped 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 emergency supply requests met legal requirements. A sample of records of private prescription supplies found that the team had recorded the prescriber's details as miscellaneous. A sample of records for the receipt and supply of unlicensed products looked at found that they did not always meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had completed training on the General Data Protection Regulations (GDPR). And the pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had procedures to provide the team with information on how to respond to safeguarding concerns. The team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training on 09 December 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And the ACT had completed the level 1 CPPE training on 07 November 2018. The team had completed Dementia Friends training in 2017. The delivery drivers reported concerns they had about people they delivered to.

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 supports new members of the team. And it provides all team members with opportunities to complete more training. The pharmacy provides feedback to team members on their performance. And it encourages team members to identify opportunities to develop their career. The pharmacy team has an open and honest culture. And the team members are good at supporting each other in their day-to-day work. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills. The team members discuss ideas to make improvements and they use these ideas to improve service delivery.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pharmacy technician who was also an accuracy checking technician (ACT), two full-time dispensers, two part-time dispensers, one full-time trainee dispenser and two part-time delivery drivers. At the time of the inspection the pharmacist manager, the ACT and three dispensers were on duty. The team members were trained to complete key tasks such as preparing the multi-compartmental compliance packs. So, the pharmacy services were not affected by unplanned absences such as team members sickness. A new member of the team had spent some time at the pharmacy before starting. So, they could meet the team and familiarise themselves with the pharmacy systems. The ACT was also the assistant pharmacy manager and helped the regional support manager. The ACT supported the pharmacist manager with tasks such as administration work. And the ACT was learning about the requirements of the new NHS pharmacy contract. So, he could share this with the team and prepare for the changes.

The pharmacy held team meetings and huddles, so the team could share information such as the outcomes from the reviews of dispensing errors and company news. The pharmacy team members also had one-to-one sessions. The pharmacy provided extra training through e-learning modules. The team members had protected time to complete the training. And they completed a quiz to show their understanding of the subject. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had asked about training to be an accuracy checker which was agreed. The ACT had taken the opportunity to discuss their career progression such as becoming a regional support manager. This led to the ACT taking up the role of helping the regional support manager.

The pharmacy had a whistleblowing policy providing information to the team on how to raise concerns. And the company invited pharmacy team members to complete a staff survey. Team members could suggest changes to processes or new ideas of working. The team had changed the storage arrangements for incomplete prescriptions. So, now the team filed the incomplete prescriptions in separate sections such as controlled drugs, antibiotics and medicines that the manufacturer could not supply. The team members found this change helped them easily find the prescription when queries arose. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people. When the pharmacist manager first started at the pharmacy she used these services to raise awareness amongst people of the range of pharmacy services available. And to improve people's understanding of

role of the pharmacist to help people with their medicines and health needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it 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. And it had 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 large, sound proof consultation room. And it had a cordoned off section of the pharmacy counter to provide privacy to people receiving their methadone doses. 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 provides services that support people's health needs. And it manages its services well. The pharmacy keeps records of deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets is medicines from reputable sources. And it generally stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via an automatic door from the car park into the health centre and pharmacy. 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 range of healthcare information leaflets for people to read or take away. The team members wore name badges detailing their role. The pharmacy had a wholesaler dealer's licence. But it only did a small amount of wholesaling. The team reported that the wholesaling activities did not impact on the delivery of the pharmacy services.

The pharmacy supplied the flu vaccinations and the malaria prophylaxis medicines against up-to-date patient group directions (PGDs). These gave the pharmacist the legal authority to administer the vaccine. And to supply the medicines. The flu vaccination service was popular. People commented on the convenience of the service and that it provided time for them to speak to the pharmacist. People also commented on the gentle technique used by the pharmacist when administering the vaccine. The pharmacist used the time with the person receiving the vaccination to offer other pharmacy services such as a medicine use review. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And it had the PPP pack containing information to give to people prescribed the valproate products. The team asked people on high-risk medicines such as warfarin for information about their doses or blood tests. And recorded this information on to the person’s electronic record (PMR).

The pharmacy provided multi-compartmental compliance packs to help around 96 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the dispensing team divided the preparation of the packs between themselves and across the month. The team kept a record of when each person was due their packs. The team members used this record to capture when they had completed each stage of preparing and supplying the packs. So, everyone in the team knew what stage the pack was at when handling queries from people. The team ordered the prescriptions in advance of supply. This allowed 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 the backing sheet supplied with the packs. And queried any changes with the GP team.

The dispenser picked the stock and then ticked the backing sheet to show they had picked and checked the medicine before dispensing it in to the packs. The team used a section to the rear of the main dispensary to dispense the medication. This provided some protection from the distractions of the pharmacy counter and the retail area. The accuracy checking technician (ACT) usually checked the packs. And the ACT marked the backing sheet to show he had completed the accuracy checks of the packs. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The pharmacy sometimes received copies of hospital

discharge summaries. The team checked the discharge summary for changes or new items. The team managed changes to packs already sent to people by getting them back, requesting prescriptions and sending out new packs. The pharmacy team monitored the frequency of changes to a person's pack. And spoke to the GP teams when people regularly had their medicines changed. So, the team could suggest moving the person to weekly supplies of their packs.

The pharmacy provided methadone and buprenorphine as supervised and unsupervised doses. The team prepared the methadone doses using an electronic Methasoft pump. The pump was linked to a laptop that the team updated with the methadone doses on receipt of a new prescription. The team stored the prescriptions in a dedicated folder. And it used clear wallets labelled with the person's name to separate each person's prescription. The pharmacist asked the person to confirm their date of birth and the dose the person was expecting before handing over their methadone. The pharmacist also asked the person to confirm the number of doses they were expecting when supplies were for them to take away.

The pharmacy provided separate areas for labelling, dispensing and checking of 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 CD 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. The pharmacy also had a triple stamp. The pharmacy team used this as an audit trail of who had clinically checked and accuracy checked the prescription. And to indicate if the pharmacist had made an intervention with the prescription. 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 pharmacy team checked the expiry dates on stock. And kept a record of this. The team highlighted medicines with a short expiry date. 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 Oramorph oral solution with three months use once opened had a date of opening of 01 October 2019 recorded. The team members took the temperatures of the three fridges each day. But they only kept a record for two of the fridges. The team members checked the temperatures of the fridge used to store the flu vaccinations. But they did not record the readings. A sample of temperature recordings for the other two fridges found they were within the correct range. And the thermometer for the fridge holding the flu vaccinations showed the temperatures were in range. 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 two CD cabinets that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no equipment to meet the requirements of the Falsified Medicines Directive (FMD). The company was trialling the FMD in other pharmacies. The pharmacy obtained medication from several reputable sources. And it received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and an internal messaging system. 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 it mostly protects 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 it used separate, marked measures for methadone. The pharmacy had three fridges to store medicines kept at these temperatures. The pharmacy used one fridge for stock, one for the flu vaccinations and the third fridge for completed prescription 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 most private information in the dispensary and rear areas, which had restricted access. The team members locked the computer in the consultation room when it was not in use. And they 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.