General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: New Mill Pharmacy, Inside New Mill Post Office, 6 Huddersfield Road, New Mill, HOLMFIRTH, HD9 7JU

Pharmacy reference: 1118785

Type of pharmacy: Community

Date of inspection: 17/10/2019

Pharmacy context

This is a community pharmacy in a building shared with a post office and a newsagent, on a parade of shops in the village of New Mill, Holmfirth. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), the NHS New Medicines Service (NMS) and the NHS urgent supply service. It supplies medicines to people in multi-compartmental compliance packs and 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 has up-to-date written procedures to help the team protect the safety and wellbeing of people who access its services. It keeps the records it must have by law. And it keeps people's private information secure. The pharmacy uses surveys to receive feedback from people who use the pharmacy, to help improve its services. The pharmacy team members have appropriate tools available to help them safeguard the welfare of vulnerable adults and children. They discuss and learn from near miss errors and dispensing incidents. And they take steps to make sure errors are not repeated.

Inspector's evidence

The pharmacy had a small dispensary located at the rear of the premises. It had a small retail area which was shared with the post office and newsagent. There was a separate pharmacy counter which was the barrier between the retail area and the dispensary. The pharmacy had a small team of a regular pharmacist and a trainee pharmacy assistant.

The pharmacy had a set of standard operating procedures (SOPs). There was an index, and so it was easy to find a specific SOP. There were SOPs for procedures such as taking in and handing out prescriptions, responsible pharmacist (RP) regulations and dispensing. The SOPs were last reviewed in 2018 and were due for the next review in 2020. This ensured that they were up to date. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The trainee pharmacy assistant described how she would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the pharmacy assistant that she had made an error. The pharmacist or the pharmacy assistant then recorded the details of the error onto a paper near miss log. They had recently discussed the importance of recording every near miss error to make sure they did not miss out on any learning opportunities. The details of the entries in the near miss log were often non-specific and the team members did not always record the reason why the error had happened. And so, they may have missed out on the opportunity to make specific changes to the way they work to ensure the error was not repeated. The pharmacist analysed the near miss errors every three months. The purpose of the analysis was for the team to identify any patterns or trends and to then consider ways to improve their accuracy. The most common type of error involved medicines that looked or sounded similar, known as LASA medicines. The team had recently reorganised the dispensary shelves to reduce the risk of a picking error happening. The pharmacy had a clear process to manage and report dispensing errors that had been given out to people. It recorded these incidents onto an incident report form and a copy was kept in the pharmacy for future reference. The report included why the incident may have happened, the action the pharmacy had taken and any learning points. The details of these incidents were also reported to The National Reporting and Learning System, which is a central database of anonymised patient safety incident reports.

The pharmacy had a poster which advertised how people could make comments, suggestions and complaints. But the poster was located behind the retail counter and so people who used the pharmacy could not see it. The pharmacy completed an annual customer satisfaction survey. But no records were available for inspection. The pharmacist explained that some people who used the pharmacy wanted

some seats to sit down while they waited for their medicines to be dispensed. They installed some chairs and made sure they offered people a seat if they had to wait in the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And they were completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. They were in order including completed headers, and entries made in chronological order. The pharmacy team checked the running balances against physical stock each month. The running balance of a random CD was checked, and it matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team members held records containing personal identifiable information in areas of the pharmacy that only they could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The waste was then destroyed using a shredder. The pharmacy assistant understood the importance of keeping people's information secure. And she had completed some basic training on information governance.

The pharmacist on duty had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The pharmacy assistant gave several examples of symptoms that would raise her concerns in both children and vulnerable adults. And described how she would discuss any concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had written guidance on how to manage and report a concern and the contact details of the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team. The team members work well together to manage their workload and ensure people receive a good service. The pharmacy supports the team member who is in training for their dispensing qualification. It achieves this by providing a structured programme and protected time to complete training regularly. The team members talk openly and honestly and can make suggestions to improve the pharmacy's services.

Inspector's evidence

The regular pharmacist worked full-time and was supported each day by the trainee pharmacy assistant except on Wednesday's, when the pharmacist worked in the pharmacy area of the premises on their own. They ensured that they had completed as much of the dispensing workload by the end of Tuesdays, so on Wednesdays, the pharmacist only had to concentrate on prescriptions that people brought to the pharmacy. The pharmacy also employed two part-time delivery drivers. A locum pharmacist covered the days the regular pharmacist did not work. The pharmacy assistant did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacist was seen supervising the pharmacy assistant throughout the inspection. And she involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments and accurately described the tasks that she could and could not perform in the pharmacist's absence.

The pharmacy assistant had been training on a Buttercups dispensing course for around five months. She completed much of her training during the working day. And received around two hours a week to train. She received support from the pharmacist through regular appraisals and the ability to ask questions when the pharmacy was quiet. The pharmacist had helped with her calculation module, for example converting milligrams to micrograms.

The pharmacist and the pharmacy assistant regularly discussed topics such as company news, targets and patient safety. They openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. These discussions were also an opportunity to give feedback to each other and discuss ideas on how they could improve the pharmacy's services. The pharmacy assistant was able to discuss any professional concerns with the pharmacist. The pharmacy did not have a whistleblowing policy. So, they may struggle to raise a concern anonymously. The pharmacy did not set any performance targets.

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 small sound-proofed room where people can have private conversations with the pharmacist.

Inspector's evidence

The pharmacy was located at the back of the ground floor of the building. The post office and newsagent counter were adjacent to the pharmacy counter. The pharmacy was clearly distinguishable from the other businesses. It was clean and was professional in its appearance. The post office and newsagent staff were not permitted access to the pharmacy.

The dispensary was small and there was limited bench space to organise the workflow. The pharmacy had soundproofed, signposted consultation room. The room was very small. There was a small bench, and fold-up chairs available. The team members did some dispensing of multi-compartmental compliance packs in the consultation room. The room was located next to the dispensary. So, they quickly moved any packs into the dispensary if the room needed to be used.

There was a small corridor which was used to store various pharmacy related items, such as medicine bottles. The floor spaces in the dispensary were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. 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 accessible to people. The pharmacy engages with people using the pharmacy and the local community to promote its services. The team members take steps to identify people taking high-risk medicines. And, they provide these people with appropriate advice to help them take these medicines safely. The pharmacy provides medicines to some people in multi-compartmental compliance packs to help them take them correctly. And it appropriately manages the risks associated with the service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The premises were accessed via a small step from the street which led to a push/pull door. The team members explained that people with mobility issues often knocked on the door to get their attention and they helped them with their queries at entrance door. The pharmacy had a portable ramp to allow people with wheelchairs or pushchairs to enter the premises. The pharmacy could provide people with a visual impairment with large print dispensing labels. The pharmacy did not advertise its opening hours and the services it offered. The team members had access to the internet to help them signpost people if they asked for a service that the pharmacy did not offer. The pharmacy was an accredited healthy living pharmacy. There was a display which included cold and flu products and leaflets, on the pharmacy counter which promoted the 'staying well during winter' campaign. The pharmacy held events at the local fair and church twice a year. It promoted pharmacy services and handed out healthcare related leaflets to people who attended.

The team members had various stickers that they regularly used 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 in the appropriate area of the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. 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 team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 60 people living in their own homes. And the it supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the prescriptions. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The pharmacy assistant completed much of the dispensing of the packs in the consultation room. She explained this was as there was limited bench space in the dispensary and she was able to work without any distractions. The team members queried any discrepancies with the person's prescriber. The packs had information attached which listed the medicines in the packs and the

directions. The pharmacy supplied information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs. The team members recorded the details of any changes such as dosage increases or decreases. But they did not always record the details of prescriber who authorised the change.

The pharmacy dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if there was a need to do so, for example, the importance of having regular blood tests. And he recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. The pharmacy assistant was aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. And she demonstrated the advice they would give people in a hypothetical situation. The pharmacy did not have any literature about the programme that it could provide to people to help them take their medicines safely. But the pharmacist explained he would use the internet to print off information if required. The pharmacist completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No affected people had been identified. The pharmacy used clear bags to store dispensed insulin and controlled drugs. This allowed the team member and the person collecting the medicine to undertake a final visual check of the medicine before the medicine was handed out.

Pharmacy only (P) medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy stored its medicines in the dispensary tidily and they were easy to find. Every two months, the pharmacy assistant checked the expiry dates of its medicines to make sure none had expired. And records were seen. The pharmacy highlighted stock that was within six months of expiring. No out-of-date medicines were found following a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could 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 pharmacy did not have any immediate plans to follow the directive. The requirements of following the directive were discussed with the pharmacist. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder and a record of the action taken was kept. The pharmacy checked and recorded the fridge temperature ranges each day. A sample was looked at. And it was within the correct ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and suitable for the services it provides. The pharmacy uses its equipment appropriately 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. 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 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. The electrical equipment had not been subjected to portable appliance testing. But appeared to in good working order.

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.