General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pinfold Pharmacy Limited, Suite 10, Room 1

Derwent View, Brackenholme Business Park, Selby, North Yorkshire, YO8 6EL

Pharmacy reference: 9010101

Type of pharmacy: Closed

Date of inspection: 20/06/2019

Pharmacy context

The pharmacy provides dispensing services at a distance, which means people cannot access the pharmacy premises. People can access the pharmacy website and contact the pharmacy by telephone. The pharmacy dispenses NHS prescriptions. The pharmacy requests prescriptions on behalf of people. And it delivers medication to people's home.

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 not all met	1.2	Standard not met	The pharmacy does not have written procedures for the team to follow when dispensing errors happen. The pharmacy does not keep records when things go wrong. And there are no arrangements for the pharmacy team members to report and learn from their own errors.
		1.6	Standard not met	The pharmacy does not keep all the records it needs to by law. And it has not done for a long time. So, this may impact on patient safety.
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 safely store all of its patient returned medicines as it should by law. There is a risk the medication could be reused or not destroyed appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy identifies some of the risks associated with its services. The pharmacy has adequate arrangements to protect people's private information. The pharmacy has some written procedures for the team to follow. But they have not been recently reviewed and the team members have not signed to say they have read them. This means there is a risk that team members may not understand or follow correct procedures and the procedures may be out of date. The pharmacy team members correct mistakes when they happen. But they don't have any procedures to follow to make sure they adequately respond to these mistakes. And they don't record the mistakes or review why they happened. So, they do not have the information to identify patterns and help reduce similar mistakes in the future. The pharmacy does not keep all the records it needs to by law. And hasn't for a long time. People using the pharmacy have some opportunities to raise concerns and provide feedback on its services. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a small range of standard operating procedures (SOPs). Most SOPs were dated August 2014, other had dates of January 2016. The SOPs didn't have review dates or any evidence of a review. The pharmacy didn't have a record of the team reading the SOPs and agreeing to 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 didn't keep records of these errors. And it didn't have a SOP to cover the management of near miss errors or one for dispensing incidents. The pharmacy had no arrangements to support the team members to review and learn from their own errors. The Superintendent Pharmacist stated that there had not been any dispensing incidents. The team identified that most errors were labelling mistakes often caused by the team not spotting that the prescription details had changed. And the team had generated the label from the last entry on the electronic patient medication record (PMR). The pharmacist reminded the team to always refer to the prescription. The team members used a scanner to check the medication they had picked. So, they could spot any errors before they reached the final accuracy check. The part-time pharmacist had rearranged the storage of medicines to help the team select the correct medicine.

The pharmacy didn't have a SOP for handling complaints raised by people using the pharmacy. The pharmacy website contained contact details for the pharmacy but didn't have information on how to raise a concern. The pharmacy had a Facebook page for people to leave comments.

The pharmacy didn't keep controlled drugs (CD) registers in accordance with legal requirements. And it didn't always record CDs returned by people. A sample of Responsible Pharmacist records looked at found that they mostly met legal requirements. But the time the pharmacist signed out as Responsible Pharmacist was not always recorded. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The trainee dispenser had read information about the General Data Protection Regulations (GDPR). The pharmacy website displayed a privacy notice. The team separated confidential waste for shredding onsite.

The pharmacy didn't have safeguarding procedures in place. The pharmacy team members had access to the internet to get contact numbers for local safeguarding teams. The part time pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults in 2017. The Superintendent Pharmacist had not done this training. The trainee dispenser had previously worked in a care home and had completed Dementia Friends training in 2017.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team and the team members have the skills to support the pharmacy's services. And they share information and experience to help ensure the safe delivery of pharmacy services. The pharmacy team members receive little feedback on their performance. So, they may miss the opportunity to set personal objectives or complete training plans to help the safe and effective delivery of pharmacy services.

Inspector's evidence

The pharmacy team consisted of the Superintendent Pharmacist who worked full time, a part time locum pharmacist and a full-time trainee dispenser. The trainee dispenser had started the training two years ago. The Superintendent Pharmacist delivered people's medicines. But was planning to recruit a delivery driver. At the time of the inspection all three team members were on duty. The trainee dispenser received support from the pharmacists and was comfortable asking questions. The pharmacy provided some extra training through information in pharmacy magazines.

The pharmacy didn't provide the team members with formal performance reviews. So, they didn't have a chance to receive feedback and discuss development needs. The Superintendent Pharmacist gave the part-time pharmacist and trainee dispenser informal feedback. The team could suggest changes to processes or new ideas of working. The part-time pharmacist had used her experience to develop the medication list for the multi-compartmental compliance packs. And had introduced folders to hold the documents for this service.

The pharmacy didn't set targets for its services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequate for the services provided.

Inspector's evidence

The pharmacy was clean and hygienic. But the storage shelves were full and untidy. This led to the pharmacy team storing some stock on the work benches used for dispensing and on the floor. The pharmacy didn’t have a sink. The team used a shared toilet in the business unit for personal use. The pharmacy did not have a sink or portable water containing unit. The team used the sink in the upstairs kitchen of the business unit for water when preparing medicines. The team rarely had to prepare medication requiring water.

The premises were secure and had restricted access to the dispensary during the operating hours.

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

Summary findings

The pharmacy provides services that support people's health needs. The pharmacist works with other healthcare professionals to help ensure people receive the medication they need. The pharmacy has some systems in place to manage its services. But it doesn't always keep records or audit trails. It has an organised system for preparing medicines in multi-compartmental compliance packs to help people receive their medication correctly and on time. The pharmacy does not keep records of deliveries. So, the team does not have evidence of supply when dealing with any queries. The pharmacy gets its medicines from reputable sources. But it does not always store and manage medicines appropriately.

Inspector's evidence

The pharmacy was closed to the public which meant that people could not access the pharmacy premises directly. People could access the pharmacy website and the contact details were on the dispensing labels for people to ring the team. A small number of people used the pharmacy website to request prescriptions. Most people telephoned the pharmacy to order their prescriptions. Or the pharmacy contacted them directly. The pharmacy website provided people with opportunities to buy over the counter products such as paracetamol. The Superintendent Pharmacist stated that very few sales were made. The Superintendent Pharmacist did some clinical work with the local GP teams.

The pharmacy provided multi-compartmental compliance packs to help 16 people take their medicines. The pharmacist assessed people requesting the service to see it would meet their needs. This included speaking to the person’s carers. And with consent the pharmacist attended the person’s home. When the assessment revealed that the service would not suit the person the pharmacist offered alternatives such as a paper record for the person to record when they’d taken their medicines. The team kept a list of people who used the service. This detailed if supplies were weekly or monthly and what type of pack the person used. The pharmacy provided packs with twice daily dose slots or packs that had slots for doses up to four times a day. The packs were shallow or deep depending on the number of medicines in the pack. Several people received the packs each week as some of their medicines were only stable for this length of time when removed from the manufacturer's packaging. The pharmacist had checked that these medicines were suitable to be in the packs. When the dose of a person's medication was often changed the pharmacy supplied the medicine in separate containers until a regular dose was prescribed. The team usually received 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 and dose times. The team referred to information supplied from the pharmacy previously used by the person when filling out the medication list. 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 team also picked up changes when labelling the prescriptions by referring to the electronic patient medication record (PMR). The team referred to the medication list and prescription when dispensing and checking the packs. The team usually recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The pharmacy sometimes received notification from the GP of medication changes. The team updated the medication list with the date of the change and who asked for the change.

The pharmacy provided separate areas for labelling and dispensing 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 pharmacy had a scanner that the team members used to check that they'd picked the correct medicine. An alert flashed on to the computer screen to tell the team member they had picked the wrong medicine. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). This identified two people who met the PPP criteria. But they had been prescribed appropriate medicines to manage this. The pharmacist had spoken to the GP teams about PPP. And advised them to update their computer systems to prompt them when they generated a valproate prescription.

The pharmacy provided a repeat prescription ordering service. The team members used an electronic system to remind them when they had to request people's prescriptions. And used this as an audit trail to track the requests. The team usually ordered the prescriptions at the beginning of the week. And prioritised the dispensing and checking of prescriptions based on how soon the person needed their medicines. The team members asked people to inform them when they had prescriptions for medicines such as antibiotics. So, the team could ensure the person received these medicines in time, rather than when the next supply of their regular medication was due. The team members at the end of the day also checked the electronic prescription screen to ensure they hadn't missed any prescriptions that the person may need. The pharmacist when delivering people's medicine went through the supply with them to make sure they had all their medication. The pharmacy team referred people needing emergency supplies of their medication to the out of hours GP service. 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 trainee dispenser usually completed the dispensed by box. But only the part-time pharmacist initialled the checked by box. The Superintendent Pharmacist didn't initial the label. And explained that was how the team knew which pharmacist had checked the prescription. But this meant that there was an incomplete audit record on the labels.

The Superintendent Pharmacist delivered people's medicines and collected prescriptions from GP surgeries. This gave him the opportunity to speak to people and deal with their queries. And to identify concerns such as people not taking their medicines. The pharmacy didn't keep a record of the delivery of medicines to people. So, there was no evidence that the person had received their medication if queries arose. The pharmacy had a cool box to hold fridge medicines during deliveries.

The pharmacy kept several loose strips of medicines removed from the packaging on the shelves. This ran the risk of losing or damaging the medication. And it meant that the team may not know if the contents were the same as the batch number and expiry date on the packet if a safety alert came through. The pharmacy team checked the expiry dates on stock. But didn't keep a record of this. The team marked medicines with a short expiry date. And after a recent re-organising of the shelves the team had removed medicines with short expiry dates. 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. The pharmacy had a small fridge to store medicines kept at these temperatures. This was full of stock which reduced the airflow inside the fridge. And may affect the temperature inside the fridge. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. The pharmacy usually kept patient returned controlled drugs (CDs) separate from in date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had scanners to meet the requirements of the Falsified Medicines Directive (FMD). But was waiting for a computer software upgrade. The pharmacy didn't have any FMD procedures and the team hadn't received any training. The pharmacy obtained medication from several reputable sources

including IPS Specials. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has most of the equipment it needs to provide safe services. And it uses the equipment in a way that 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 didn't have CE equipment to accurately measure liquid medication. The Superintendent Pharmacist stated that the pharmacy team rarely had to measure out water for preparing medicines. Most prescriptions were for regular medicines rather than one off items such as antibiotic suspensions. When the team members had to measure out water they used an oral syringe. But this is not best practice and may not be as accurate as using recognised CE 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. The team used cordless telephones to make sure telephone conversations were held in private. And used passwords to prevent unauthorised access to mobile phones used by the pharmacy team.

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.