General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicare Chemists Limited, Riverside Centre, Huddersfield Road, Holmfirth, West Yorkshire, HD9 3AZ

Pharmacy reference: 9010103

Type of pharmacy: Community

Date of inspection: 29/04/2019

Pharmacy context

The pharmacy is on a high street in Holmfirth and is open just over 45 hours over six days per week. The pharmacy team mainly provide NHS dispensing and sell a range of over-the-counter medicines. And offer services including medicines use reviews (MUR), the NHS New Medicines Service (NMS) and seasonal flu vaccination via NHS and private patient group direction (PGD). They provide a substance misuse service, including supervised consumption (no current clients), and multi-compartmental compliance packs to approximately 250 people. Approximately 80 per cent of the workload is preparing packs. And this helped the pharmacy to plan and manage the workload. The pharmacy provides its services to varied local population.

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	Pharmacy team members are not following the systems in place to learn from mistakes. And, they do not make changes to help stop mistakes happening again.
		1.6	Standard not met	The pharmacy does not keep the necessary records to help manage its services safely.
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	4.2	Standard not met	The pharmacy does not provide people with easy access to the information they need to help them take their medicines safely.
		4.3	Standard not met	The pharmacy does not monitor temperatures in the fridge. So, it cannot know if the medicines stored in the fridge are safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy has procedures in place to identify and manage risks. But, they have not been reviewed for over two years. Some procedures are duplicated. So, the pharmacy team might be confused about how to do things in the agreed, safest and most effective way. The pharmacy team know how to keep people's information secure. And they know what to do if there is a concern about the welfare of a child or vulnerable adult. The pharmacy keeps some records required by law. But, other records that help to safely run the pharmacy are not kept. Systems are in place for the pharmacy team to record mistakes that happen. But, pharmacy team members don't always record their mistakes. And they don't fully explore and discuss why mistakes happen. So, the team do not always learn from the mistakes. And they do not always make changes to stop similar errors in the future.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The procedures had last been reviewed in 2015. And it had scheduled the next review of the procedures for 2018. But they had not yet been reviewed. Pharmacy team members had read and signed the SOPs after the last review in 2015. Procedures were in place to help the pharmacy manage the new requirements under the Falsified Medicines Directive (FMD). They had been implemented and signed by the team in February 2019. But, the procedures had been added to the file of standard operating procedures (SOPs) without the old SOPs being removed. The pharmacy defined the roles of pharmacy team members in some SOPs but not all. The dispenser said that day to day tasks were also defined verbally. And, if there was anything she felt unqualified to deal with, she would refer to the pharmacist.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. The dispenser confirmed she was told she had made a mistake by the pharmacist. But, nothing else about the mistake was discussed. Team members didn't record all mistakes they made. Pharmacy team members made very few records of near misses. There were four records made in the last six months. The records made did not capture any information about why a mistake had been made. The pharmacist advised that if he noticed a pattern, he would raise it with the team. But, he did not record any analysis. And, he could not remember when he last analysed the mistakes that had been made. The dispenser gave an example of attaching an alert sticker in front of the shelf where calcium preparations were kept. The sticker had been added after a mistake where she had selected the wrong preparation. The pharmacy had a procedure for dealing with dispensing errors that had been given out to people. But, there were no records of any dispensing errors. The pharmacist advised there had been errors, but they had not been recorded. He gave an example where the wrong strength of ramipril capsules had been given out to someone. He advised he had told pharmacy team members to be more careful. But, nothing else had been changed to stop the same or similar mistakes happening again.

The pharmacy had Patient Group Direction (PGD) documents available for last flu vaccination season. But, the documents had not been signed by the superintendent pharmacist or the pharmacist delivering the vaccinations. The pharmacist had a declaration of competence available. It showed he had completed the required training to administer vaccinations. The pharmacist explained he had carried out a visual risk assessment of the pharmacy before delivering the vaccination service. But, he had not recorded the assessment or any findings. He said there had not been any findings for improvement identified.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. The pharmacist said that people had commented about insufficient space in the consultation room. So, the pharmacy team had removed a leaflet rack from the consultation room to provide more space.

The pharmacy had up to date professional indemnity insurance in place.

The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity monthly since January 2019, including methadone. But, it had checked registers less often before that. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen. The pharmacy did not record when stock expiry date checks had been carried out. And, pharmacy team members did not monitor or record fridge temperatures. The thermometer available was broken and had stopped working approximately a week ago. But, there were no records of fridge temperature monitoring from before the thermometer broke. The pharmacist advised temperatures were looked at occasionally, but, they did not look at them every day. And records had not been kept for several months.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it shredded confidential waste. Pharmacy team members had trained to protect privacy and confidentiality. They had completed an online training course about the General Data Protection Regulations (GDPR) in March 2019. And, they had signed confidentiality agreements in June 2018. The pharmacy had a procedure in place detailing requirements under GDPR.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise her concerns in both children and adults. She explained how she would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding teams for advice. The pharmacy had a procedure and contact details available for the local safeguarding service. But, they were last reviewed in 2015. So, the information might be out of date. The pharmacist had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) in February 2017. But, the pharmacy did not provide regular training for other members of team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training ad-hoc. But, they do not regularly reflect on their own performance. They discuss any training with the pharmacist. But, they don't complete regular planned training. And they don't have a regular formal process to discuss their performance or individual training needs. So, it may be difficult to tailor learning to the needs of the person and to make sure their knowledge and skills are up to date. The pharmacy team do not always establish and discuss specific causes of mistakes. This means they may miss chances to learn from errors and make changes to make things safer.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and a dispenser. There was also a full-time pre-registration pharmacist employed. The pharmacist explained that other dispensers were brought from other branches to help manage the planned preparation of multi-compartmental compliance packs at the busiest time of the month. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having discussions with the pharmacists about current topics. The pharmacy had an appraisal process, but the dispenser had not had an appraisal for approximately three years. She had recently received a questionnaire that asked her to evaluate her own performance and identify any learning needs. And, her responses were going to be discussed at her upcoming appraisal. No objectives had been set at her last appraisal.

The dispenser explained that he would raise professional concerns with the pharmacist, other pharmacists in the company or the superintendent pharmacist (SI). She felt comfortable raising a concern. And confident that his concerns would be considered. But, she wasn't sure about how long it would take for things to be addressed. The pharmacy did not have a whistleblowing policy. So, they may not be clear about how to raise concerns anonymously.

The pharmacy team communicated with an open working dialogue during the inspection. The dispenser advised she was told by the pharmacist when she had made a mistake. The discussion that followed did not fully explore why she had made the mistake. And, changes were not always made to prevent a mistake happening again.

The pharmacy was set targets by the organisation. Its targets included reaching a defined number of medicines use review (MUR) and New Medicines Service (NMS) consultations. Pharmacy team members cofirmed nothing happened if they did not reach their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC which provided a sink with cold running water and other facilities for hand washing.

Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

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

Summary findings

The pharmacy is accessible to people. It stores, sources and manages medicines safely. But, the pharmacy team don't always label stock medicines correctly. So, they may miss medicines that have expired or been recalled. The pharmacy does not regularly monitor temperatures inside the fridge. So, it does not know if the medicines are stored at the correct temperature or of they are safe to use. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. But, they do not regularly provide people with medicines information leaflets. The team takes some steps to identify people taking high-risk medicines. And it provides them with some advice. But the team don't have any written information for people to take away. So, people may not have correct information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessible via level access from the street. There was no bell or information to tell people how to attract staff attention of they needed help gaining access to the pharmacy. The pharmacy team were able to make large print labels and instruction sheets to help people with visual impairment. And, the pharmacy's information on the NHS Choices website was regularly updated.

The pharmacist signed the checked by boxes on dispensing labels. This was to maintain an audit trail of who was involved in the dispensing process. But, the dispenser did not sign labels. So, the audit trail was not complete.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. It provided descriptions of the medicines supplied on the packaging. But, it did not provide people with patient information leaflets about their medicines each month. The pharmacy team documented any changes to medicines provided in packs on the patient's electronic record. But, they did not record who had informed them of the changes. The dispenser explained that changes were confirmed by receiving a valid prescription before any packs were altered. They also received hospital discharge summaries. Summaries were reconciled against the pharmacy's master records. And, any discrepancies were queried with the patients GP and resolved.

The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up.

Pharmacy team members checked medicine expiry dates every year. It did not keep records of the checks. They recorded items with less than 12 months expiry on a monthly stock expiry sheet, for removal in the month before their expiry. Pharmacy team members checked the dates of new stock when it was put away. And items were added to expiry lists if necessary. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

The pharmacy obtained medicines from four licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Several boxes were found

on the pharmacy shelves that contained mixed batches of medicines. Some amber bottles were found containing medicines that had been removed from their original containers. The bottles had a label attached stating the name and strength of the medicine. But, the label did not record the batch number or expiry date of the medicines. Other amber bottles were found inside medicines cartons. These bottles did not have a label attached. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs).

The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. But, it did not monitor minimum and maximum temperatures in the fridge.

The contents of the pharmacy fridge were tidy and well organised. Temperatures within the fridge were not monitored or recorded. Pharmacy team members said the thermometer available was broken and had stopped working approximately a week ago. But, they had no records of fridge temperature monitoring from before the thermometer broke. The pharmacist advised that temperatures were looked at occasionally. But, they did not look at them every day. And records had not been kept for several months.

The pharmacis advised he would discuss the risks of valproate in pregnancy with anyone presenting a prescription for valproate who was in an at-risk group. The pharmacy had one regular patient who received valproate who was a person who may become pregnant. The pharmacist had checked whether she was aware of the risks when she had first presented a prescription at the pharmacy. And, had counselled about pregnancy prevention and provided her with information materials. But, he advised he had not asked her again or provided her with any further information materials. The pharmacy did not have a stock of information materials to hand out to people.

The pharmacy delivered medicines to people. But, records of deliveries were kept for one week and then shredded. There were no records to see and no evidence that deliveries were signed for by a recipient.

Procedures were in place to help the pharmacy manage the new requirements under the Falsified Medicines Directive (FMD). They had been implemented and signed by the team in February 2019. But, the procedures had been added to the file of standard operating procedures (SOPs) without the old SOPs being removed. Pharmacy team members said they had not received any training. Some products were being scanned, but not all.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The equipment available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The dispensary fridge was in good working order. Access to all equipment was restricted and all items were stored securely.

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.