General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stone Pharmacy, 23A Gowthorpe, Selby, North Yorkshire, YO8 4HE

Pharmacy reference: 9010571

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

The pharmacy is in the centre of Selby. It dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy provides people with emergency supplies of their medication via the NHS Urgent Medicine Supply Advanced Service (NUMSAS).

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 generally identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy has written procedures for the team to follow. But some team members have not read the procedures. This means there is a risk they may not understand or follow correct procedures. The pharmacy team members respond adequately when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't record all errors or review them. This means the team does not have information to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs) provided by the Numark organisation. These provided the team with information to perform tasks supporting the delivery of pharmacy services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. One of the team had read and signed the SOPs signature sheets to show they understood and would follow them. The full-time dispenser who started in January 2019 was reading through them and had signed the ones she had read. The delivery driver had not signed the SOPs. The pharmacy had up to date Indemnity insurance.

On some 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. A sample of the error records looked at found that the team did not always record details of what had been prescribed and dispensed to spot patterns. The team occasionally recorded their learning from it and actions they had taken to prevent the error happening again. The pharmacy had a SOP for handling dispensing incidents. A recent delivery error had been recorded on to a piece of paper. But was not transferred to a formal record so that the team could capture the causes, learning points and actions taken to prevent the same mistake. The team including the driver discussed the error. And identified that the bag label was correct, but a team member had attached it to the wrong bag. Since this incident the team had changed the processes for bagging completed prescriptions. This changed involved the team checking the bag label against the prescription, and for multi compartmental packs the backing sheet. The team had not recorded the error on the electronic patient record (PMR) for both people. So, there was nothing to alert the team members to the mistake when they accessed the PMR for these people. And prompt them to check they had selected the correct person.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. The pharmacy team used surveys to find out what people thought about the pharmacy.

A sample of controlled drugs (CD) registers looked at found that they mostly met legal requirements. Some CD registers didn't have the headers completed. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. The dispenser knew what she could or could not do whilst the pharmacist was not at the pharmacy or not signed in as the Responsible Pharmacist. A sample of records of private prescription supplies looked at found that the team had not recorded the prescriber's details. Or, the prescriber's details were wrong.

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 pharmacy displayed some details on the confidential data kept and how it complied with legal requirements. The pharmacy didn't display a privacy notice in line with the requirements of the General Data Protection Regulations. The team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had not completed Dementia Friends training. The team responded appropriately when safeguarding concerns arose. This included when the team members identified people who showed signs of confusion about their medicines. And they contacted the GP team to see what could be done to help the person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to support the pharmacy's services. Or are to be enrolled on appropriate training courses. The pharmacy team members receive feedback on their performance. So, they have opportunity to progress in their role or take on a new role to help the safe and effective delivery of services. The team members discuss errors and how they can make improvements. And they act to support the safe and efficient delivery of these services.

Inspector's evidence

The pharmacist owners and a regular locum pharmacist covered most of the opening hours. The pharmacy team consisted of a full-time qualified dispenser, a part time dispenser and a delivery driver. The pharmacy also had a new member of the team who started a few weeks earlier. The pharmacy was enrolling this team member on to the dispensing and counter assistant training once they had finished their probationary period. At the time of the inspection the locum pharmacist, the qualified dispenser and the delivery driver were on duty.

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 level 3 national vocational qualification (NVQ). And had asked to do the medicine counter assistant training as they had not worked in a pharmacy that sold medicines. The pharmacy owners agreed to both training requests.

Team members could suggest changes to processes or new ideas of working. The dispenser had developed spreadsheets to record prescription requests and as an audit trail for the supply of multi-compartmental compliance packs. The locum pharmacist had suggested having an island unit in the dispensary to provide more work space. This had been agreed and installed. The pharmacy did not set targets for services such as Medicine Use Reviews (MURs).

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and 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. The team used this for private conversations with people.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. 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 adequately. The pharmacy obtains its medicines from reputable sources. And it mostly stores them correctly. It keeps records of the medicines supplied in multi-compartmental compliance packs and it has records of the deliveries it makes to people at home. So, it can deal with any queries effectively. But the pharmacy team has not completed the valproate Pregnancy Prevention Programme checks. And the team doesn't have the required information to pass to people. So, people may not have the correct information to take their medicines safely.

Inspector's evidence

People accessed the pharmacy from the high street in Selby. The consultation room was large and had easy access for people using wheelchairs. The window displays detailed the opening times and the services offered. The team had access to the internet to direct people to other healthcare services.

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 pharmacy team had not completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy did not have the PPP information cards and leaflets to pass on to people. The team were aware of the PPP initiative. People taking high risk medicines such as methotrexate occasionally provided the pharmacy team with information about blood tests and doses. But the team didn't record this information.

The pharmacy provided multi-compartmental compliance packs to help around 49 people take their medicines. The pharmacy had a list of people receiving the packs. The team used the list to show when the pack was due. The team usually ordered 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. Some GP teams sent the prescriptions close to the date the team supplied the packs to the person. The team members had identified the risk of increased errors if they had to dispense and check the packs in a short period of time. So, they dispensed the trays in advance by referring to the backing sheet. This listed the medicines, the dose and dose times. The pharmacist didn't check the packs dispensed at this stage. The team kept the dispensed packs in a dedicated area of the dispensary waiting for the prescription. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and the backing sheet supplied with the packs. Once the team received the prescription the pharmacist completed the clinical and accuracy check on the packs. The team used a section of the main dispensary to dispense the medication. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. Following an error when one person received another person’s pack, the team checked the bag label against the prescription and backing sheet when bagging up the packs. The team members added a note to the list of people receiving the packs to remind them to do the extra check of the bag label. The pharmacy had a spreadsheet to record when the person had collected their pack. The team used a notice board to record information such as when a person was in hospital. And updated the medication list with any changes following hospital admissions or requests from the GP.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in separate baskets labelled with the person's name. The pharmacists placed the doses due each day together in one basket that they labelled awaiting collection. The pharmacists didn't separate these doses. The pharmacist checked the prescription a second time at the point of supplying to the person. After the pharmacists had supplied the dose they placed the empty bottle in a basket labelled collected. One of the pharmacists had introduced this to act as a prompt to complete the back of the prescription to record the supply.

The team members provided a repeat prescription ordering service. The dispenser was responsible for ordering people's repeat prescriptions. And asked people collecting their medication what they wanted for next time. The dispenser also rang people to see what medicines they wanted for their next prescription. The dispenser had developed a spreadsheet to record prescription requests and monitor outstanding requests. The dispenser passed on information to people from their GP such as the need to attend the surgery for a medication review.

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 had a text messaging service to inform people when their repeat prescriptions or owings were ready. The team placed completed prescriptions awaiting delivery in boxes labelled with the day of the week. 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 members checked the expiry dates on stock. But didn't keep a record when they had done the date check. 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 metronidazole 200mg/5ml with 12 weeks use once opened had a date of opening of 21 May 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team labelled most bottles containing tablets removed from the original pack with the batch number and expiry date. This meant the team could check the expiry and identify if the bottle contained affected stock if a safety alert came through. 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 a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had scanning equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacy didn't have procedures for FMD. And the team hadn't received any training. The pharmacy obtained medication from several reputable sources. 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 and actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect 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 used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures.

The computers were password protected and access to peoples' 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 private information in the dispensary and rear areas, which had restricted access. The team 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.