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: 29/04/2021

Pharmacy context

The pharmacy is in the centre of Selby. The pharmacy's main activities are dispensing NHS prescriptions and delivering medication to people's homes. The pharmacy supplies medicines in multi-compartment compliance packs to help several people take their medicines. The pharmacy was inspected during the COVID-19 pandemic.

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	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 mostly identifies and manages the risks associated with its services including the risks from COVID-19. It has up-to-date written procedures that the pharmacy team follows. And it completes all the records it needs to by law. The pharmacy protects people's private information properly. The pharmacy team members respond appropriately when errors occur. They discuss what happened and they take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments for all team members to identify their personal risk of catching the virus. The risk assessment also identified the steps needed to support social distancing and infection control. The pharmacy had installed a plastic screen on the pharmacy counter to provide the team with extra protection. The outer edges of the screens displayed key messages relating to COVID-19 symptoms, social distancing requirements and infection control. The retail area was large enough to provide space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The dispensary was large which enabled team members to adhere to social distancing requirements. The team had access to Personal Protective Equipment (PPE) which team members wore when serving people at the pharmacy counter. The team members working in the dispensary didn't wear PPE. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and many tests had been supplied. A notice on the pharmacy counter provided the team with information to relay to people on how to use the tests.

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. All team members except the recently recruited delivery driver had read and signed the SOPs signature sheets to show they understood and would follow them.

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 known as near miss errors. A sample of the near miss 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 members recorded their learning from it and the actions they had taken to prevent the error happening again. The team demonstrated the changes made following a review of common near miss errors. This included separating medicines that looked and sounded alike (LASA) to reduce the risk of picking the wrong product. The pharmacy had a procedure for handling dispensing incidents. The pharmacist reported there had not been any recent dispensing incidents. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And there was a poster informing people of how to raise a concern or give feedback.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The team described an appropriate response if a pharmacist had not arrived at the pharmacy and was not

signed in as a RP. The pharmacy had a procedure for handling confidential information. And the team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members were not aware of the Ask for ANI (action needed immediately) initiative but had not had an occasion when a person presented at the pharmacy asking about it.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the basic skills to support its services. Team members work well together and support each other in their day-to-day work. Pharmacy team members receive informal feedback on their performance. And the pharmacy provides ongoing training to the team members to support the development of their knowledge and skills.

Inspector's evidence

The new Superintendent Pharmacist (SI) and the other new pharmacist owner covered the opening hours. The pharmacists worked together once or twice a week. This was mostly to support each other with the checking of compliance packs. The pharmacy team consisted of three pharmacy apprentices who had started between three and four months ago and a delivery driver in post a few weeks. At the time of the inspection one of the pharmacist owners and the three pharmacy apprentices were on duty.

The pharmacist owners had provided the pharmacy apprentices with internal training on the pharmacy procedures and computer system during the first few weeks of employment. Due to the change of ownership there had been a slight delay with enrolling the team on to the training courses. The SI recently received confirmation from the training provider of the enrolment process. The team read articles in the pharmacy journals and had received training from the pharmacists on how to access the electronic medicines compendium (EMC) to find out information about medication. The pharmacy apprentices were observed helping each other such as chasing up prescriptions or directing where medicine stock was located. One of the team had experience from working in a medical centre so supported the other team members when handling people's queries when they telephoned the pharmacy.

The pharmacy team held regular huddles to share experiences and issues of concern. The pharmacy provided team members with informal feedback on their performance. The team could suggest changes to processes or new ideas of working and team members were working together to review the procedures for the supply of compliance packs. This had resulted in a process for chasing up outstanding prescriptions and introducing an additional pharmacist check.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. The pharmacy 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. During the pandemic the pharmacy team regularly cleaned the pharmacy. And hand sanitising gel was available for the team and people accessing the pharmacy to use. 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 premises were secure and 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.

The pharmacy had a large, soundproof consultation room that was easily accessible. The team used this for private conversations with people. The pharmacy had installed a sliding window in the consultation room that the team used to speak to people when handing over their methadone doses.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it generally manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team usually carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy from the high street in Selby. The retail area 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 a repeat prescription ordering service for some people. The team members used a spreadsheet to record prescription requests and monitor outstanding requests. And they used labelled baskets to hold outstanding prescription requests to be chased up with the surgery. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and directed people receiving valproate to the information card embedded within the medicine packaging. The pharmacy didn't have anyone prescribed valproate who met the PPP criteria. People taking other 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 supplied medicine to some people as supervised and unsupervised doses. And it prepared the doses a day before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored all the prepared doses securely as required but in the same basket labelled with the date the dose was supplied. There was no separation of different people's doses to reduce the risk of selecting the wrong one. The pharmacist checked the prescription a second time at the point of supplying to the person.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. The service was popular and the team received regular requests for the service from people and healthcare professionals. The new pharmacist owners were reviewing the service to see if the pharmacy had reached capacity to safely provide the service and to identify areas of improvement. The pharmacists were concerned that to take on more people whilst they reviewed the service could risk the safe delivery of the service. So, the pharmacy had stopped offering it to new people whilst the review took place. The pharmacy had a list of people receiving the packs which showed when their next supply was due. The pharmacy used a spreadsheet embedded on to the computer as an audit trail of the completion of stages such as the receipt of the prescription. 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 into the packs. Each person had a record listing their current medication and dose times. The team stored baskets holding the stock for dispensing into the packs on dedicated shelves labelled as 'packs to be dispensed'. The dispensed packs were moved to dedicated shelves waiting to be checked by the pharmacists. The pharmacists were aware of the risks associated with supplying medicines in the packs and introduced an additional pharmacist check into the process. One pharmacist completed a clinical check and accuracy check. The other pharmacist completed a separate accuracy check. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. 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 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 had checked by and dispensed by boxes on the dispensing labels. The team initialled the boxes to record who had dispensed and checked the prescription. A sample of completed prescriptions showed both boxes were initialled. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. Throughout the pandemic the pharmacy had seen an increase in requests for the delivery service. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 the delivery driver did not ask people to sign for receipt of their medication.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and placed a coloured dot on medicines with a short expiry date. The team did not record when date checking had taken place. 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 team recorded fridge temperatures most days and a sample found they were within the correct 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 a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacists received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. And took appropriate action in response to the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably 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. The pharmacy had a fridge to store medicines kept at these temperatures.

The pharmacy 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.