General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Circle Pharmacy, Backstone Business Centre, Suite 2, Saltaire Road, Shipley, West Yorkshire, BD18 3HH

Pharmacy reference: 9010859

Type of pharmacy: Internet / distance selling

Date of inspection: 23/03/2022

Pharmacy context

The pharmacy is in a business centre in Shipley. And it has a distance selling NHS contract. Pharmacy team members dispense NHS prescriptions. They provide medicines to people in multi-compartment compliance packs who live in care homes and nursing homes. And to people who live in their own homes. They deliver medicines to people. The inspection was completed during the COVID-19 pandemic.

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 adequately identifies and manages risks to its services. And it keeps the records it must by law. Pharmacy team members regularly record and discuss mistakes they make. And they learn from these to reduce the risks of similar mistakes. Team members understand their role to help protect vulnerable people. And they suitably protect people's private information. The pharmacy mostly has documented procedures it needs relevant to its services. But some key procedures are missing. So, pharmacy team members may not always be clear about the safest and most effective ways to complete their tasks.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The superintendent pharmacist (SI) had reviewed the procedures in 2021. And had scheduled the next review of the procedures for 2023. Pharmacy team members had read the procedures. And they had signed each one to confirm their understanding. Pharmacy team members were clear about where the procedures were kept if they needed to refer to them. There were a small number of processes in the pharmacy that did not have an accompanying documented procedure. These included documented procedures for responding to and recording near miss and dispensing errors. And for the handling and disposal of medicines waste from care homes and other people. But pharmacy team members were able to clearly describe these procedures. And how they would handle these scenarios safely and effectively. The pharmacy defined the roles of the pharmacy team members based on their levels of qualification in a dedicated SOP. Pharmacy team members also had their responsibilities defined verbally through discussion each day. The pharmacy had completed a risk assessment at the beginning of the Covid-19 pandemic to help them manage the risks of infection. And a copy of the documented assessment was available during the inspection. The pharmacy had since relaxed some of its previous infection control measures recently. For example, the pharmacy no longer asked pharmacy team members to wear a face covering while they worked. This was not in line with current UK Health Security Agency (UKHSA) guidance. This was discussed. And pharmacy team members donned masks when they were asked to by the inspector.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. They discussed their errors and why they might have happened. And they used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as rosuvastatin and rivaroxaban, to help prevent the wrong medicines being selected. The superintendent pharmacist (SI) analysed the data collected every month to look for patterns. But they did not discuss their analysis with the rest of the team. Records of near miss errors were available up. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. During the inspection, pharmacy team members could not find any previous records made of dispensing errors. So, the quality of error reporting and analysis could not be assessed. They gave their assurance that errors were recorded and discussed when an error was discovered and rectified. But the pharmacy did not have a documented procedure to help team members do this in the most effective way. The pharmacy displayed patient safety and learning in the area where medicines were prepared. The display showed information about how pharmacy team

members could avoid making common mistakes. And information about commonly used medicines and their indications. The displayed also gave people some case studies of typical errors made elsewhere, how these were discussed and analysed, and the actions people had taken to make their pharmacies safer.

The pharmacy did not have a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally. And any complaints were immediately referred to the pharmacist to handle. There was no information available for people about how to provide the pharmacy with feedback, either on paper or on the pharmacy's website. Pharmacy team members explained that people would usually telephone to give their feedback. The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete. It kept running balances in all registers. Pharmacy team members audited the methadone register against the physical stock quantity every week. But they did not audit the pharmacy's other CD registers regularly. The pharmacy 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. And this was also complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription and emergency supply records electronically. Pharmacy team members did not always accurately record the date they had dispensed a private prescription in the sample of records seen.

The pharmacy kept sensitive information and materials secured in the pharmacy. The pharmacy's NHS contract meant the pharmacy premises could not be accessed by the public. Pharmacy team members collected confidential waste in dedicated bags. These were sealed when full and taken for secure destruction. The pharmacy did not have a documented procedure to help team members understand how to effectively manage private information confidentiality. But pharmacy team members clearly explained how important it was to protect people's privacy and how they protected confidentiality.

Pharmacy team members gave some examples of symptoms that would raise their concerns about vulnerable children and adults, specific to the distance selling nature of the pharmacy. They explained how they would refer to the pharmacist. The pharmacy had a documented procedure explaining how team members should raise their concerns about children and vulnerable adults. And this included contact information for local safeguarding teams. There was also a guide displayed in the pharmacy to help team members decide how to deal with a concern. Pharmacy team members completed training via e-learning at various times between 2021 and 2022.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They regularly complete ongoing training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions. And the pharmacy responds by making changes to help improve its services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist and four dispensers. Two of these people were training to be pharmacy technicians. And one was also the pharmacy's delivery driver. Pharmacy team members kept their skills and knowledge up to date by complete e-learning modules ad-hoc throughout the year. The most recent example was training about safeguarding. They explained they sometimes found it difficult to find time during work to complete training. But they hoped this would improve as the pressures on the pharmacy caused by the pandemic reduced. Pharmacy team members explained they also discussed topics with the pharmacist and each other. The pharmacy did not have a formal appraisal or performance review process for pharmacy team members. A dispenser explained they would raise any learning needs verbally with the superintendent pharmacist (SI). And they felt they would be supported by being signposted to relevant reference sources or by discussion to help address their learning needs.

A pharmacy team member explained they would raise professional concerns with the SI or the pharmacy's owner. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their points would be considered. A dispenser explained how an idea for improvement had been taken forward that had allowed the team to reorganise the area where medicines were prepared. They were in the process of creating storage and dispensing space in a room off the main dispensary. And they had reorganised the area used to store medicines for delivery. They explained this had made the pharmacy safer for them to work in. And it had improved bench tidiness to provide more space for them to work safely. The pharmacy had a whistleblowing policy in place. And team members knew how to access the procedure. Pharmacy team members were also aware of organisations outside the pharmacy where they could raise professional concerns, such as the NHS or GPhC. Pharmacy team members communicated with an open working dialogue during the inspection. The pharmacy owners did not ask pharmacy team members to meet any performance related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has suitable measures in place to prevent unauthorised access to the premises.

Inspector's evidence

The pharmacy premises could not be accessed by the public because of its distance selling NHS contract. The pharmacy was clean and well maintained. Most areas of the pharmacy were tidy and well organised. And the benches where medicines were prepared were mostly tidy and well organised. The pharmacy's floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained heat and light to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And it provides its services safely and effectively. The pharmacy sources and stores its medicines appropriately. And it manages its medicines effectively. The pharmacy helps some people to take their medicines correctly by providing them in compliance packs. And pharmacy team members provide these people with necessary written information about their medicines.

Inspector's evidence

The pharmacy had a distance selling NHS contract. So, the pharmacy's premises were not accessible to the public. The pharmacy provided some information about its services on its website. And pharmacy team members explained the company were in the process of developing a new website. Pharmacy team members were also able to speak several languages spoken locally, including Urdu, Punjabi, Gujrati and Inko, as well as English. They explained how they usually communicated with people by phone. But there were some people who preferred to communicate with team members by email. A dispenser gave an example of a patient who was struggling to communicate with the pharmacy by phone. And who was unable to use email. So, the dispenser had visited the persons home, before the Covid-19 pandemic, to help them. And to explain to them how to take their medicines safely.

The pharmacy provided medicines to several care and nursing homes. And they provided these medicines in multi-compartment compliance packs. Pharmacy team members ordered prescriptions for people in the homes based on written orders received from home staff. They reconciled these orders against the prescriptions received. And resolved any queries and anomalies quickly. Any changes made to people's medicines were recorded using the pharmacy's electronic patient medication records (PMR) system. Any affected packs were retrieved from the home quickly, amended or replaced and returned to the home, usually on the same day. The pharmacy provided medicines in packs that included comprehensive information about the medicines inside, the time they needed to be administered and the details of the person the medicines belonged to. The information often also included a photograph of the person to help home staff prevent administration errors. The pharmacy provided paper copies of medicines information leaflets for all the medicines it provided to the home once a year. And if a medicine was newly prescribed to someone. The pharmacy also supplied medicines in multi-compartment compliance packs to people in their own homes when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they routinely provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in these packs on the person's PMR.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And she checked if the person was aware of the risks if they became pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy did not have any stock of some of the information materials to give to people to help them manage the

risks of taking valproate. This was discussed. And a pharmacy team member gave her assurance that the necessary materials would be obtained as soon as possible. The pharmacy delivered medicines to people. It used an electronic system to manage and record deliveries which uploaded information to the driver's handheld device. Under normal circumstances, people signed on the driver's device to confirm they had received their prescription. But the driver was not currently asking people to sign to help prevent transmission of coronavirus. The driver signed to confirm a delivery had been made successfully. Pharmacy team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The electronic system also allowed pharmacy team members to track the delivery driver's progress. This helped them to deal with any queries while the driver was out of the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves. It kept all stock in the secure pharmacy premises. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members explained they received a significant quantity of medicines waste from care homes. And they were required to sort and store the medicines until they were collected by a waste disposal contractor each month. Team members showed the room where waste medicines were kept, away from the rest of the pharmacy's medicines. Pharmacy team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months. And up-to-date records were seen. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry. And they removed expiring items at the beginning of their month of expiry. The pharmacy responded to drug alerts and recalls. It quarantined any affected stock found for destruction or return to the wholesaler. It recorded any action taken. And records included details of any affected products removed.

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 people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had equipment available to help prevent the transmission of COVID-19. These included gloves, hand sanitiser and face masks. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It had suitable bags available to collect and segregate confidential waste. It kept its computer terminals in the secure pharmacy premises. And these were password protected. The pharmacy's fridge was in good working order. It restricted access to all equipment and it stored all items 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.