General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Thorpe Willoughby Pharmacy, 31 Fox Lane, Thorpe Willoughby, Selby, North Yorkshire, YO8 9NA

Pharmacy reference: 9011565

Type of pharmacy: Community

Date of inspection: 30/11/2021

Pharmacy context

This community pharmacy is located in the centre of Thorpe Willoughby, a village near Selby. The pharmacy's main activity is dispensing NHS prescriptions. And it provides some medicines in multi-compartment compliance packs to help people take their medication. The pharmacy also provides the seasonal flu vaccination service. The pharmacy was inspected 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	2.2	Good practice	The pharmacy actively encourages and supports team members to develop their knowledge and skills. It provides a range of opportunities for team members to use their skills and to identify their training needs. The pharmacy gives team members protected time to complete their training.
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. It has up-to-date written procedures that the pharmacy team follows. And it mostly completes all the records it needs to by law. The pharmacy team members respond well when errors occur. They openly discuss what happened and they take suitable action to prevent future mistakes. The team members understand their role in safeguarding the safety and wellbeing of children and vulnerable adults.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The team members wore Personal Protective Equipment (PPE) face masks and used hand sanitiser gel. And the pharmacy had installed a plastic screen on the pharmacy counter to provide the team with extra protection. The retail area provided enough space for people to be socially distanced from each other. The size of the dispensary enabled team members to mostly adhere to social distancing requirements. The pharmacy provided lateral flow tests to people as part of a national service.

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team had read and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

On most occasions the pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacist and team member involved discussed the possible cause of the error and how to prevent it from happening again. The pharmacy kept records of these errors known as near misses. The records were completed by the team member involved and the entries looked at reflected individual team member's reflections. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error happening again. The pharmacy recorded errors that reached the person known as dispensing incidents. All the team members were informed of the dispensing incidents to raise their awareness and to share learnings. The team regularly discussed ways to reduce the risk of errors and they took action to prevent similar errors from happening again. This included adding warning stickers to shelves holding medicines that looked and sounded alike (LASA). The team also separated some LASA medicines on to different shelves to reduce the risk of picking errors. The team attempted to supply people with different brands of medication when they were prescribed more than one strength of a medicine. This meant people had two distinct packaging to reduce the risk of them taking their medication incorrectly. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. But there was no clear information in the retail area advising people on how to raise a concern. The team had received several positive comments since the pharmacy relocated to the centre of the village where it was more accessible for people.

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. Some records of private prescription supplies were missing either the date of supply or the date on the prescription. The pharmacy didn't display details on the confidential data it kept and how it complied

with legal requirements. It also didn't display a privacy notice. The team had completed training about the General Data Protection Regulations (GDPR). And team members separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. And the 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 had completed suicide awareness training and knew about the Ask for ANI (action needed immediately) initiative. The team had not had the occasion to report such concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of qualifications and skills to support its services. And it is good at providing team members with opportunities to develop their knowledge and skills. The team members support each other in their day-to-day work. And they identify areas for improvements to the delivery of pharmacy services.

Inspector's evidence

The pharmacist owner who was also the Superintendent Pharmacist covered most of the opening hours. Locum pharmacists provided cover when required. The pharmacy team consisted of a three part-time trainee dispensers, and two part-time trainee medicines counter assistants (MCA). The pharmacy employed two delivery drivers who covered this pharmacy and the other pharmacy owned by the company. At the time of the inspection the SI, two of the trainee dispensers and the two trainee MCAs were on duty.

The SI supported the trainees with their learning and offered them protected time to complete the training when required. The pharmacy provided additional online training modules to provide the team with a wide range of up-to-date knowledge and skills. The team had recently completed a training module focusing on obesity. The pharmacy provided team members with informal feedback on their performance and discussed their development needs. The SI and the team members used these opportunities to identify new roles and responsibilities. The SI identified team members with the skills for specific tasks to support him and had discussed the roles with these team members. One of the trainee dispensers used their administrative skills to support the SI with completing the NHS Pharmacy Quality Scheme (PQS). Another trainee dispenser wished to develop their clinical skills from their experience working in a care home. So, the SI had asked if they wanted to support the ear syringing service that was being developed. This was agreed and the SI had arranged appropriate training.

The team worked well together and felt comfortable speaking to the SI about a range of issues. The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, one of the dispensers had obtained a poster to advise people of the option to return their used inhalers to the pharmacy for appropriate destruction. Rather than placing them in general household waste.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services provided. The pharmacy has suitable facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. The pharmacy had restricted access to the dispensary during the opening hours. It had separate sinks for the preparation of medicines and hand washing. 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 defined professional area. And items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room. The team used this for private conversations with people and when providing services such as the flu vaccination.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that assist people with their health needs. And it manages the pharmacy services well. The team members take opportunities to offer additional services that support the health needs of the local population. The pharmacy keeps suitable records of the deliveries it makes to people's home. This enables the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had relocated earlier in the year from a site in the village that was not as easy to get to. The team had been informed by several people that they didn't know there was a pharmacy in the village before the relocation. The team provided people with information on how to access other healthcare services. And the pharmacy kept a small range of healthcare information leaflets for people to read or take away. The SI had liaised with a local group to arrange an ear syringing service in the pharmacy. The final arrangements including team training were in place. The pharmacy team had been asked by many people if the pharmacy provided an ear syringing service as it was not being offered in the local medical centres. The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). But the pharmacy didn't have anyone prescribed valproate who met the criteria. The pharmacy had PPP information to give to people when required.

The pharmacy provided the seasonal flu vaccination service which was very popular. The team had planned the service before it started to ensure an efficient flow of people into the pharmacy. And to ensure the SI and pharmacy team could safely support the service along with other pharmacy services. The planning included training for team members to identify people who were reacting to the vaccines whilst observing them after their vaccination. The pharmacy mostly provided a walk-in service and it limited the number of people in the pharmacy. To reduce the number of people presenting for the walk-in service at the same time the team members asked people to wait in their cars. And monitored when people arrived so they knew who was due their vaccination. The service was provided against up-to-date patient group directions (PGDs) which gave the SI the authority to administer the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 80 people take their medicines. It also provided packs to people living in two small care homes. One of the trainee dispensers managed the service with support from others. To manage the workload the team divided the preparation of the packs across the month and colour coded the weeks. The team used a calendar wall chart to mark each week so all team members knew which packs were being prepared. The team usually ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items and the dispensing of the medication into the packs. The care home teams used the prescription repeat slips to indicate the medications needed and sent them to the pharmacy to order the prescriptions. The dispensary had limited workspace available so the team used a small room off the dispensary to prepare the packs. This provided some protection from the distraction of the retail area. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. Each person had a record listing their current medication and dose times which

the team checked against received prescriptions. The pharmacy was sent copies of hospital discharge summaries via the NHS discharge medicines service (DMS). The team checked the prescriptions sent from the GP team against the person's list of current medication and the discharge summary to identify any discrepancies. The SI reported this was a very useful service.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. 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 of completed prescription showed that the team completed both boxes. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And it kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. Due to the pandemic the pharmacy didn't ask for a signature from the person receiving the medication. The driver marked the delivery sheet to show the delivery was made. If the person was not at home the delivery driver left a note informing the person of the failed delivery. The pharmacy had a dedicated section for failed deliveries, so the team could easily find them if the person came to collect it.

The pharmacy obtained medication from several reputable sources. The pharmacy team regularly checked the expiry dates on medicine stock. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The team usually recorded the dates of opening for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records 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 pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

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 reference resources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy had two fridges to store medicines kept at these temperatures. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy stored completed prescriptions away from public view. The pharmacy held private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.