General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Derwent Pharmacy, Norton Road, Norton, Malton, North Yorkshire, YO17 9RD

Pharmacy reference: 9011576

Type of pharmacy: Community

Date of inspection: 22/06/2022

Pharmacy context

The pharmacy is on a high street in Norton village, close to the town of Malton. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines to people in multi-compartment compliance packs to help them take their medicines correctly. And they deliver medicines to people's homes. The pharmacy provides people with services via the NHS Community Pharmacist Consultation Service (CPCS). And provides various other services, including the NHS New Medicines Service (NMS).

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	4.2	Good practice	The pharmacy considers the needs of the local community to help shape how it delivers its services. Pharmacy team members are good at using opportunities when providing services to advise people about their health and wellbeing to help them achieve the best health outcomes.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

Pharmacy team members manage the risks of providing their services well. The pharmacy has appropriate procedures and risk assessments in place to help them do this effectively. Pharmacy team members record the mistakes they make during dispensing. And they suitably discuss and reflect on these mistakes to make changes to help prevent similar mistakes from happening again. They understand their responsibilities in protecting people's private information and they keep this information safe. And they know how to help protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The pharmacy manager and superintendent pharmacist (SI) had reviewed procedures when the pharmacy moved to a new premises in 2021. They had scheduled the next routine review of the procedures for 2023. Pharmacy team members had read the procedures and they had signed each one to confirm their understanding. They were clear about where the procedures were kept if they needed to refer to them. The pharmacy defined the roles of pharmacy team members based on their levels of qualification in each SOP. Pharmacy team members also had their responsibilities defined verbally through discussion each day.

The pharmacy had a set of risk assessment documents to help pharmacy team members manage risks in various areas of the business. Some of these focussed on operational areas, such as hand washing and hygiene, manual handling and properly securing the pharmacy. And others focussed on risks associated with the pharmacy's services, such as using the consultation room, providing supervised consumption for people, and providing vaccination services. Each assessment comprehensively recorded and discussed the identified risks, and the risks were graded using a low, medium, and high system. The pharmacy rated the risks again once pharmacy team members had made changes to mitigate the risks identified. Pharmacy team members had read and signed the assessments since they had moved to the new premises. The pharmacy manager reviewed the risk assessments every two years or if there was a significant event that required the pharmacy to reassess key risks. They also generated a new risk assessment for each new service they provided.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They used tablet devices in various locations around the pharmacy to capture the details of near miss errors when they happened. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating and highlighting look-alike and sound-alike (LASA) medicines on the shelves, to help prevent the wrong medicines being selected, such as etoricoxib and Edoxaban. 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. The pharmacy manager analysed the data collected every six months to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a patient safety briefing. The length of time between analyses was discussed with the SI. They agreed that more frequent analysis of error date might help to make changes to improve safety more quickly. Pharmacy team members used an encrypted social media group application to share learning about their mistakes, especially with people

who were not working at the time of an incident. They did not discuss any information on the application that could identify patients.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally and by using questionnaires given to people at the pharmacy counter. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback. A pharmacy team member explained that in response to feedback they received during the Covid-19 pandemic, they had rearranged the seating in the pharmacy's retail area to help people maintain social distancing, while keeping the same number of chairs to accommodate people who were unable to stand while they waited.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and kept running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity at least monthly. 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 accurate private prescription and emergency supply records. A veterinary prescription was found that the pharmacy had dispensed recently. The prescription did not contain all the wording necessary to make it comply with current law. This was discussed, and the SI gave their assurance that the prescription would be returned to the prescriber for amendment. And pharmacy team members would complete retraining.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated secure bins, which were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. A pharmacy team member gave some examples of symptoms that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every two years and had last completed training in 2021.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. And managers make sure team members working have the right skills for the services they provide. Pharmacy team members complete appropriate training to help keep their knowledge and skills up to date. They share and discuss their learning with each other. And they feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

During the inspection, the pharmacy team members present were the superintendent pharmacist (SI), the responsible pharmacist (RP), two locum pharmacists, a pharmacy technician, five dispensers, three medicines counter assistants and a delivery driver. The SI explained there was always at least two pharmacists on duty to help the pharmacy deliver its services, as well as keeping up with its prescription workload. The pharmacy was also able to call on some regular locum pharmacists who helped to cover staff absences and manage busier periods.

The pharmacy had a suite of e-learning modules available for team members to use to help keep their skills and knowledge up to date. Pharmacy team members completed training ad hoc each month. The modules they completed often related to seasonal conditions, such as recent modules on hay fever and sun care. They had also recently completed training about suicide awareness. The pharmacy manager often suggested subjects for pharmacy team members to complete training on. Pharmacy team members discussed training subjects via an encrypted social media group application. And they also used this platform to discuss learning points from errors that had happened in the pharmacy, making sure their discussion did not include any patient-sensitive information. Pharmacy team members received an appraisal with the pharmacy manager once a year, allowing them to reflect on their own performance and identify their own learning needs. Team members set objectives at each appraisal to work towards. And they were supported by the pharmacy manager and pharmacists to help them learn and reach their objectives.

A pharmacy team member explained how they would raise professional concerns with the pharmacists, the pharmacy manager, or the SI if necessary. Pharmacy team members felt it was easy to give feedback to managers about the pharmacy and the way they provided services. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. One recent example had been during the planning process for their new pharmacy premises. The pharmacy’s owner had consulted with team members about the layout of the pharmacy. Pharmacy team members had provided their feedback about several areas, such as the amount of bench space available, the flow of prescriptions through the dispensary and where computer terminals would be positioned. These suggestions were considered, and the owner made changes to the plans to help make sure the space in the pharmacy worked well for everyone. The pharmacy had a whistleblowing policy. And pharmacy team members knew how to access the procedure.

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 a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had three private consultation rooms available. Pharmacy team members used the rooms to have private conversations with people.

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

Pharmacy team members manage the pharmacy's services well to make sure that people receive the care they need. They consider the specific needs of their local community to help tailor their services appropriately. The pharmacy's services are accessible to people, including people using wheelchairs. It has systems in place to help provide its services safely and effectively. It sources its medicines appropriately. And it stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment. Pharmacy team members used an online translation service to help communicate with people who spoke other languages, such as Polish. The pharmacy had recently identified a lack of access locally to an emergency defibrillator. Pharmacy team members felt the pharmacy was ideally placed in the community to offer the equipment because it was next door to the town's train station. And because the town was in the heart of a mainly rural area. So, they organised various fundraising events to be able to buy the equipment and to provide all pharmacy team members with first aid and basic life support training. The pharmacy had installed the emergency defibrillator on the wall outside the pharmacy. Pharmacy team members were responsible for maintaining the equipment and replacing any parts after the unit was used.

The pharmacy provided advice to people about new medicines they had been prescribed as part of the NHS New Medicines service. Pharmacy team members had been trained to help identify people who had been prescribed new medicines. They referred people to the pharmacist to have a consultation about their new medicines and any newly diagnosed conditions. The team were currently proactively identifying people with newly diagnosed high blood pressure, type 2 diabetes, and people who were having their asthma inhalers changed from an aerosol device to a dry-powder device as part of a local prescribing initiative. The pharmacy had also devised a suite of questions for the pharmacist to ask people during these consultations. This helped the pharmacist find out more about people's general health and lifestyle. It provided them with the opportunity to discuss areas where the pharmacy might also be able to help improve someone's health and wellbeing and achieve the best outcome for people. And to help people navigate the anxiety of being diagnosed with a new condition. The SI gave some specific examples of consultations the pharmacy had provided where team members had been able to use the suite of questions to provide tailored health advice and help to improve people's wellbeing. The pharmacy kept a collection of information materials to give to people to help them understand various conditions. Pharmacy team members kept these resources up to date. The SI explained that several people who had engaged with the service had returned to the pharmacy to ask further questions as they developed their understanding of their conditions.

The pharmacy supplied medicines to some people daily as supervised doses. Pharmacy team members explained that at the beginning of the Covid-19 pandemic, people who received their medicines this way had their prescriptions changed to unsupervised doses and to collect more than one day's dose at a time. This was to help protect these people and pharmacy team members from the risks of transmitting Covid-19. It soon became apparent to the pharmacy team that several people were

struggling to manage their medicines without supervision or to handle more than one day of medicines at a time. Pharmacy team members discussed their concerns with the local substance misuse service who provided the prescriptions and managed people's care. The pharmacy carried out a risk assessment of the pharmacy and their infection control measures to establish if they could safely provide supervised doses to people again. They successfully implemented extra infection control steps, such as gowns and face visors, and managed the control of people through the pharmacy and the consultation room. And this meant they were able to offer people supervised consumption again. The SI described the positive response they had received from people as a result. And people had been grateful because they felt more comfortable and able to manage their treatment.

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 they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme. The pharmacy had stock of information materials to give to people to help them manage the risks of taking valproate. The pharmacist asked to see information from someone's latest blood test results if they were receiving warfarin. They checked to make sure their results were within the correct range, and they recorded the information before dispensing their medicines.

The pharmacy supplied medicines to people in multi-compartment compliance packs 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. They provided people with patient information leaflets about their medicines when they were newly prescribed. But they did not routinely provide leaflets to people after that. This was discussed, and the SI gave their assurance that people would be provided with information leaflets about their medicines regularly. Pharmacy team members held comprehensive records of any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and where they were placed in the packs. Team members also kept records of communications they had with the GP surgeries about people's packs, to help resolve future queries quickly. The pharmacy also provided medicines to a local nursing home. It provided these medicines in their original packs. And medicines were accompanied with a medicines administration record (MAR) chart. This was to help nursing home staff keep records of what had been prescribed, how it should be administered and when doses were given to people. The pharmacy delivered medicines to people's homes. It used an electronic system to compile a list of the deliveries which was uploaded to the delivery driver's hand-held device. The system allowed pharmacy team members to track the delivery driver's progress throughout their delivery run. And this helped them to locate prescriptions and resolve queries from people who telephoned the pharmacy. The information uploaded to the driver's device included detail about each prescription, such as the presence of an item that needed to be stored in a fridge or a controlled drug. The pharmacy's delivery van was equipped with an electric cool box to help keep fridge medicines cold until they reached people. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines on shelves. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members recorded checks of medicine expiry dates that they made in various areas of the

pharmacy every week on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to three months before their expiry. And they removed expiring items during the month before their expiry. The pharmacy responded to drug alerts and recalls. It quarantined any affected stock for destruction or return to the wholesaler. And it recorded any action taken. The 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, use of the internet and devices to help train people how to use their inhalers. The pharmacy had some equipment available to help prevent the transmission of Covid-19. These included hand sanitiser and plastic screens. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had a suitable container available to collect and segregate its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view.

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.