General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Elland Pharmacy, 15 Huddersfield Road, Elland, West Yorkshire, HX5 9BA

Pharmacy reference: 9011808

Type of pharmacy: Community

Date of inspection: 04/04/2024

Pharmacy context

This pharmacy is located within a medical centre in a residential area. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides the NHS Pharmacy First service, seasonal flu vaccinations and a blood pressure check service.

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 effectively manages risks to make sure its services are safe, and it completes the records that it needs to by law. Its team members record their mistakes so that they can learn from them, and they make changes to help reduce the risk of the same type of mistakes from happening again. The pharmacy team keep people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and had been read and signed by team members. Responsibilities were listed in SOPs.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and were recorded by the team member on a log sheet. The superintendent pharmacist (SI) had explained to the team why it was necessary for team members to sign the dispensed and checked by boxes to help identify which member of the team was responsible in the dispensing process. The team discussed that there was a no blame culture and understood how recording near misses helped with reflecting upon and learning how the mistake had occurred and how it could be avoided. The SI had previously reviewed near misses but had not done so for the past six months. This could mean that any trends or patterns were not identified. The pharmacy were members of a group and had received bulletins in the past with information about common trends and patterns from near miss or dispensing errors across the group's members. Following conversations with team members shelf edges had been labelled for some medicines and team members had been asked to take breaks and concentrate when dispensing. The SI said there had not been any reported dispensing mistakes which had happened, and the medicine had been supplied (dispensing errors), a process was in place to follow in the event that it did.

The correct RP notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and information about it was included in the practice leaflet. The leaflet also had information on how matters could be escalated. Due to previous incidents team members triple checked quantities with people at the point of handout. The team ordered and kept aside specific brands of medicines for people who had specific preferences.

Private prescription records, emergency supply records, responsible pharmacist (RP) records, records for unlicensed medicines supplied and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct.

Assembled prescriptions which were ready to collect were not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had been briefed about it. The pharmacy stored confidential information securely and separated confidential waste which was shredded. Pharmacists had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

Team members, including the delivery driver, had all completed training about safeguarding vulnerable people. Information on how to raise concerns was kept on the computer. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern as well as the steps they would take if they had concerns but would first speak to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload and they receive appropriate training to carry out their roles safely. The pharmacy helps its team members to keep their knowledge and skills up to date. Team members get regular feedback to help improve their performance. And they can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy was open extended hours. The pharmacy team comprised of the RP, who was also the SI, and three trained dispensers. Other team members who were not present during the inspection included another trained dispenser, a delivery driver and two regular pharmacists. The pharmacy also had regular locum pharmacists who covered shifts. The team felt there were enough staff manage the workload safely. They felt that they worked well together and were observed to be up to date with the workload. Since the pharmacy had relocated, the business had grown but team members were able to effectively manage the workload. The SI reviewed services such as the multi-compartment compliance pack service to ensure the number of people signed up to the service could be safely and effectively managed by the team.

Team members asked appropriate questions and provided advice to people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. And they referred to the pharmacist if unsure. The SI held annual appraisals with team members as part of which further training needs and development was discussed. Team members were also provided with feedback on an ongoing basis. Team members felt they were able to provide the SI with feedback and had regular catchups about how things could be done differently. The team tried to learn one new thing every day. This could be in relation to operational tasks, services, clinical information related to health care conditions and personal development. As part of this team members were asked to read information leaflets and the team also did role play for further learning.

Team members all completed learning on the eLearning for healthcare (elfh) portal. They were also members of an online training portal through which they could completed training on a wide range of conditions, services, medicines and healthy living. From time to time the SI had discussions with the team about different focus areas. This was either done on a one-to-one basis or for the whole team. The SI used literature from pharmacy press and wholesalers to help with this.

The SI prepared learning packs when new services were to be launched. In addition to this the SI held a one-to-one discussion with all the pharmacists and then tested their understanding. Formal meetings were held when needed depending on the nature of the issues needed to be discussed. The SI came into the pharmacy to speak to pharmacists if there was anything he needed to discuss. There were no targets set for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available so people using the pharmacy can have a private conversation with its team members.

Inspector's evidence

The pharmacy was situated in a health centre and was accessible via a shared main entrance. The pharmacy premises were clean and organised. The dispensary was small but had been arranged in a way to maximise workspace. Workbenches were being used to store a number of dispensed prescriptions waiting to be checked and some waiting to be bagged. The team explained that this was not usually the case, and it was the result of the bank holiday weekend and staff holidays. Multi-compartment compliance packs were prepared in the evenings when it was quieter. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by a contracted cleaner. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of service which are accessible and generally well managed. The pharmacy gets its medicines from licensed suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

The pharmacy was easily accessible from the car park and there was step free access into the premises with wide automatic doors. The car park had dedicated disabled parking bays. The shop floor was clear of any trip hazards and the retail area was accessed easily. The pharmacy had a hearing loop available. Some team members were multilingual, and the pharmacy used translation applications. Team members were familiar with any additional needs of regular customers and helped them to ensure they could access the services provided. The pharmacy had good working links with the adjoining surgery and people were frequently referred by the reception team. The pharmacy ran different health campaigns on a monthly basis using material sent by a third-party group.

Team members felt the NHS Pharmacy First service had the most positive impact on the local population. The SI described that it was popular but felt that the IT access could be improved which would help the service be provided more efficiently. The SI was an advanced clinical practitioner and had demonstrated to colleagues how to use equipment such as the otoscope. Pharmacists had completed online training and watched training videos whilst some had also attended face to face training. The SI had printed summaries of the different services and displayed this in the dispensary. Other team members including dispensers had been briefed about the service by the SI. The SI had also provided information to the local GPs about the service specification. The SI did not provide any prescribing services from the pharmacy.

The pharmacy had an established workflow in place. Prescriptions were processed by one of the dispensers and then stock was picked and labelled by another dispenser. These were then checked by the pharmacist and left in an allocated area where a dispenser or pharmacist performed a third visual check and bagged the medicines. 'Dispensed-by' and 'checked-by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Team members had individual log in detail for accessing the computer systems which created an audit of who had done the labelling. Baskets were used to separate prescriptions, preventing transfer of medicines between different people.

The SI was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). Team members were aware of the need to dispense sodium valproate in its original pack and ensure any warnings were not covered with labels. A sticker had been attached to the shelf edge to remind team members to ensure sodium valproate was always dispensed in its original pack. People were counselled on the use of their medicines and a note was made on their electronic record to show this. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

Some people's medicines were supplied in multi-compartment compliance packs to help them take

their medicines at the right time. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. The pharmacy received a discharge summary following a person's stay in hospital. Prescriptions were ordered by the pharmacy. Any other changes were checked and confirmed with the surgery. Prescriptions were labelled and clinically checked by the pharmacist and packs were prepared by the dispensers and finally checked again by the pharmacist. A few packs were seen to be stored unsealed as they were waiting to be checked. The team agreed that there were possible risks of storing medicines in this way and provided and assurance that packs would be sealed as soon as they were prepared in the future. Assembled packs seen were labelled with mandatory warnings and information leaflets were supplied monthly. Product descriptions were not routinely included, which could make it difficult for the person to identify what each medicine was. Backing sheets were also not securely attached and there was a risk that these could be lost, and the person would have no information about the medicines in the pack, how to take them and any warnings. The SI agreed that he would review the service and ensure changes were made.

The pharmacy's medicine delivery service was provided by a designated driver. If someone was not home, medicines were returned to the pharmacy and delivery was reattempted. Signatures were obtained for CDs delivered.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines were stored on the shelves, in a tidy and organised manner. Fridge temperatures were monitored daily and recorded; they were within the required range for the storage of cold chain medicines. And CDs were kept securely. Expiry date checks were completed by the team every three to six months. Short-dated stock was marked with stickers. A date checking matrix was available, but this had not been updated. So, the pharmacy may not be able to show when the last date check was completed or what medicine stock had been checked. No date expired medicines were found on the shelves checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via email, these were discussed with the team and actioned. The SI retained a printed copy of actioned alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is maintained and kept clean so that it is safe and ready to use.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Separate labelled measures were available and used for liquid CDs to avoid cross contamination. Equipment was clean and ready for use. A medical fridge was available. A blood pressure monitor, and an otoscope were available and used for some of the services provided; the SI said these were replaced regularly. Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.