General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Citywide Health - Haxby Pharmacy, 6 Wyre Court, The Village, Haxby, York, North Yorkshire, YO32 2ZB

Pharmacy reference: 9011821

Type of pharmacy: Community

Date of inspection: 22/07/2024

Pharmacy context

The pharmacy is in a parade of shops in the village of Haxby, near York and is open seven days a week. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide other healthcare services including the NHS Pharmacy First Service, a private travel health service including vaccinations, Covid-19 vaccinations, and the NHS Pharmacy Contraception Service. And they deliver medicines to people's homes.

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. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy has most written procedures it needs relevant to its services to help team members provide services safely. Team members record their mistakes so that they can learn from them. But they don't always discuss or capture key information or analyse their mistakes to identify patterns. So, they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) reviewed the SOPs on a rolling cycle. But some SOP reviews were due in 2022 and 2023 and had not been completed. This meant they may not reflect the pharmacy's current practice. Pharmacy team members had signed to confirm they had read and understood the SOPs. The pharmacy received regular patient safety focus bulletins each month from the SI, which communicated key topics and learning from dispensing incidents across the company's pharmacies. A recent example was a bulletin that included information about the importance of properly recording near miss mistakes and learning from recent errors involving controlled drugs (CDs). And provided links to training videos about how to properly use the pharmacy's electronic patient medication records (PMR) system for certain tasks.

The pharmacy had considered some risks when introducing new services. For example, it provided a travel health service to people, which included providing people with medicines and vaccinations for travel overseas. It used patient group directions (PGDs) as the legal mechanism to provide these medicines. The pharmacy also offered the NHS Pharmacy First service to people. Before providing these services, pharmacy team members had discussed and mitigated some risks of providing them to people. These included making sure that team members were properly trained to provide the service. And making sure the pharmacy had the necessary equipment and medicines in place. But they had not documented their assessments to help aid future reflection and to help inform changes as they continued to provide the services.

The pharmacist highlighted and recorded mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. They used an electronic system to record the information. The pharmacist discussed mistakes with the team member involved. But they rarely discussed or recorded specific information about why the mistakes had been made. Or the changes they had made to prevent a recurrence and to help aid future reflection and learning. And they did not regularly analyse the data to establish patterns of mistakes. So, they may miss opportunities to learn and make improvements. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. The records available gave a clear explanation of the error. But these records also did not always document information about causes from all team members involved, to help make the most effective adjustments to improve safety.

The pharmacy had a documented procedure for handling complaints and feedback from people. The process was advertised to people in the pharmacy's retail area and on their website. Team members

explained people usually provided verbal feedback, or by leaving reviews online. Following people's feedback, they gave a recent example of changing the way they managed repeat dispensing (RD) prescriptions by using the PMR more effectively to track when prescriptions were due to be dispensed. And this helped to make sure prescriptions were available when people needed them before they ran out of their medicines.

The pharmacy had current professional indemnity insurance in place. It kept accurate CD registers electronically and maintained running balances for all registers. Pharmacy team members audited these balances every month. Checks of the running balances against the physical stock for three products were found to be correct. The pharmacy kept a register of CDs returned by people for destruction. It maintained a responsible pharmacist record electronically, and it was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures. The pharmacy kept complete private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins. Once full, the bins were taken to the nearby GP surgery, where they were collected and taken for secure destruction. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. And the completed training about how to manage privacy and confidentiality each year.

Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would discuss their concerns with the pharmacist, operations manager, or SI if necessary. They were also aware of how to find information about key local safeguarding contacts by using the internet. Team members were unable to find the pharmacy's safeguarding procedure during the inspection. They completed safeguarding training each year.

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 complete training to help keep their knowledge and skills up to date and are able to complete training at work. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a trainee pharmacist, four qualified dispensers and a trainee dispenser. Team members completed training modules ad hoc when asked to by head office. The most recent examples of completed training included safeguarding, antimicrobial stewardship and infection prevention and control. Team members also explained how they had regular discussions with the pharmacists and other colleagues. The pharmacy was open for 12 hours each day, except Sunday. On weekdays, the pharmacists organised their working patterns to overlap, which allowed them to work together for at least three hours. This provided regular opportunities for one pharmacist to focus on delivering services to people, while the other concentrated on managing and providing people's prescriptions.

The trainee pharmacist explained how they felt well supported with their learning in the pharmacy. And support was provided by other pharmacists who worked at the pharmacy, as well as their training supervisor. The explained how they were given regular opportunities to undertake tasks usually reserved for the pharmacist, under supervision. And they explained how they felt comfortable to raise questions if they felt something was outside their competence. The pharmacy provided the trainee with one day of protected learning time every two weeks.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, operations manager, or SI. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. Team members were unsure about how to access the process. But they were aware of how they could raise concerns with the GPhC or the NHS.

Team members explained how they communicated well with each other to manage their workload. And this open dialogue was seen during the inspection. Team members felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they managed prescriptions where medicines were owed to people. And how they had changed the way they order medicines stock so that the right medicines are available as soon as possible for people. The pharmacy asked team members to achieve various targets, mainly relating to the services they provided to people. The pharmacy received regular progress updates from their head office. And the team were supported to meet their targets by head office colleagues.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. And it has a consultation room where people can speak to pharmacy team members privately. It provides an adequate space for the services it provides. But team members could improve their general organisation to help them make the most efficient use of the space available.

Inspector's evidence

The pharmacy was clean and well maintained. Its area for preparing prescriptions was small and had a limited amount of bench space for team members to use to dispense the volume of prescriptions it received. Team members generally kept these benches tidy and well organised to help maximise the space they had available. But some benches were cluttered with dispensing baskets or stock. The pharmacy's floors and passageways were generally free from clutter and obstruction. And the pharmacy kept equipment and stock on shelves throughout the premises where possible. But there were some areas where team members had no choice but to store items on the floor, which increased the risk of people tripping and falling.

The pharmacy had a private consultation room, which was clearly signposted, and pharmacy team members used the room to provide services from. And to have private conversations with people. The pharmacy also had an automated prescription collection point available for people to use to collect their medicines from. And people could access their medicines 24 hours a day from outside the pharmacy. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink with hot and cold running water and other hand washing facilities. The pharmacy kept its heating and lighting to acceptable levels. And its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It has systems in place to help it provide services safely and effectively. Team members make effective use the available technology. And they generally provide people with advice and information about higher-risk medicines. The pharmacy sources its medicines appropriately. And it generally stores and manages its medicines as it should. But the pharmacy could store some of its medicines more effectively to help reduce the risks of mistakes.

Inspector's evidence

The pharmacy had ramped access from the street via an automatic door, which provided suitable access for people using wheelchairs or prams. Pharmacy team members could provide large-print labels and instruction sheets to help people with a visual impairment access services. And they would use written communication to help people with a hearing impairment.

When people visited the pharmacy to access the travel health service, pharmacy team members completed a consultation questionnaire with them to determine key pieces of information for the pharmacist. The questionnaire included information about where the person was travelling and for how long, as well as questions about the person's medical history. The pharmacist used the information to inform their discussions with people and to help decide the best medicines to provide for the person's needs. The pharmacist kept records of each consultation, which included details of the medicines and vaccinations provided. And the batch numbers and expiry date of medicines where necessary.

Team members clearly explained how they used the PMR's barcode scanning technology at each stage of the dispensing process. Each prescription was clinically checked before it could be released for a team member to dispense. The clinical check could only be carried out by the pharmacist, according to access rights that had been set up for their individual login. The pharmacy did not print prescriptions it received electronically. Team members viewed the electronic prescriptions on screens placed around the dispensary. Team members demonstrated how they picked medicines from the shelves and scanned the barcodes on the packs. The system blocked any further progression of the prescription through the system if a team member scanned the incorrect medicine. They were unable to proceed until they scanned the correct product. If the product contained a QR code, the system also alerted them if they scanned a medicine that had exceeded its expiry date or that had been subjected to a manufacturers alert or recall. The pharmacist performed the final accuracy check of the prescription, which included scanning the box and the QR code on the attached dispensing label. Some dispensed items were flagged for a manual check by the pharmacist, such as boxes containing mixed batches of medicines, packs containing a different quantity to the original pack size and certain higher-risk medicines, such as CDs. Once the pharmacist had sealed the bag, they scanned the barcode on the bag's label and assigned the bag to a shelf, ready for people to collect or for the pharmacy to deliver. Team members used a handheld device to locate the bag when people arrived at the pharmacy, which helped to reduce the time people waited in the pharmacy.

The pharmacy had an automated prescription collection point. This allowed people to collect their prescriptions from outside the pharmacy 24 hours a day, without the need to speak to a pharmacy team member. People were able to choose and consent to having their completed prescriptions placed in the system for them to collect. But CDs and items requiring storage in the fridge were not stored in

the collection point. People received a unique PIN code by electronic message when their prescription was ready. Team members explained that if the pharmacist needed to speak to someone about their medicines, which were to be collected at the collection point, they would telephone them when they clinically checked their prescription at the start of the dispensing process. This gave them the opportunity to provide people with the necessary information about how to take their medicine safely. And for people to ask questions. But the pharmacy did not actively promote ways for people to contact the pharmacy if they had questions about their medicines or health if they received their medicine from the system, rather than having it handed out by a pharmacy team member.

The PMR system kept an audit trail of every team member involved at each stage of the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people. It recorded the deliveries it made. 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 trainee pharmacist explained how pharmacy team members counselled people receiving prescriptions for valproate if appropriate. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And checked if the person was on a Pregnancy Prevention Programme and taking regular effective contraception. Team members were aware of the requirements to provide valproate to people in the manufacturer's original packaging.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested, to help people use their medicines safely. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. But they did not regularly provide people with patient information leaflets about their medicines each month, to help them fully understand their medicines. Team members documented any changes to medicines provided in packs. And there was an SOP to help them do this properly. But team members did not always follow the SOP. And the ways they recorded these changes was varied and inconsistent. This meant they might find it difficult to deal with any future queries or concerns about people's medicines provided in packs.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every three months, and they recorded these checks. They highlighted items due to expire in the next twelve months by attaching a sticker to the pack and recording the item on a monthly stock expiry list. They removed expiring items at the end of the month before they were due to expire. Pharmacy team members explained how they acted when they received a drug alert or manufacturers recalls. And they recorded the actions they had taken.

Due to lack of available shelf space, the pharmacy stored some stock in large boxes kept on shelves under a bench. Some of the boxes contained different strengths and pack sizes of the same medicines, such as co-codamol. And other boxes contained a number of medicines within the same category, for example contraceptive medicines. This was discussed with team members. And with the SI after the inspection. They explained how they were working hard to reduce the amount of stock held in the pharmacy. And the SI was supporting them to achieve this quickly. This would help to make more shelf space available to store medicines more safely. They also explained how use of the PMR system's scanning technology would alert them if they selected a medicine incorrectly.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available to provide its services, which it properly maintains. And the team 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 it 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. It kept its computer terminals in the secure areas of the pharmacy, away from public view, and these were password protected. And bags of medicines waiting to be collected were kept in the secure areas of the pharmacy, away from public view, so people's private information was protected. The pharmacy restricted access to its equipment. It had a set of clean, well-maintained measures available for liquid medicines preparation.

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.