General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 42 Austhorpe Road, Crossgates, LEEDS, West Yorkshire, LS15 8DX

Pharmacy reference: 1039671

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

This community pharmacy is on a busy street near a large shopping centre in the Leeds suburb of Crossgates. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And the supervised methadone consumption 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	1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team members pro-actively respond when people using the pharmacy raise concerns. So, they can improve the efficient delivery of pharmacy services.
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 team members manage the pharmacy services well. They identify risks that may affect the safe delivery of services. And they act to address them. The team members use technology such as scanning bar codes to help make pharmacy services more efficient.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has arrangements to protect people's private information. And it keeps most of the records it needs to by law.

Inspector's evidence

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 SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy kept the SOPs electronically. The team members accessed the SOPs and answered a few questions to confirm they had read and understood them. The pharmacy received alerts about new SOPs or changes via an internal notification system. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. If the team member involved was busy and the prescription was not urgent the pharmacist kept it to one side for the team member to see. The team member involved made a record of the near miss error on to an electronic recording system. The pharmacy recorded dispensing incidents electronically. Following a delivery error, the pharmacist manager spent time with the delivery driver to remind them of the importance of following the SOP. And to always ask the person to confirm their name and address before handing their medicines over and getting a signature from the person. The pharmacy reviewed the near miss errors and dispensing incidents using monthly and annual patient safety reports. The pharmacist manager led on this and shared the results with the team. A recent report detailed the actions taken by the team to tidy and rearrange the shelves, so the medicine stock was in the correct place. The team had identified that near miss errors were often caused by medicines being in the wrong location on the shelves. The team also used plastic dividers to separate different strengths of the same product. Another report highlighted a decrease in errors with multi-compartment compliance packs after the team adopted the company best in class system. The team members used this system to create an efficient workflow to safely provide this service. The team members attached labels to drawers holding products that looked and sounded alike (LASA). The wording on the label was designed to prompt the team member selecting the product to check what they had picked.

The pharmacy had started using the Well offsite dispensary in October 2019. The pharmacist had checked the accuracy of the first 300 prescriptions dispensed at the offsite dispensary. After completing this exercise and finding no errors the pharmacist reduced the checking of the prescriptions from the offsite dispensary to one from each batch sent to the pharmacy. The pharmacist also checked split prescriptions when some medicines were dispensed at the offsite dispensary and the rest dispensed at the pharmacy. And recorded the outcome from these checks. So, they could spot trends or any concerns.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The team had received complaints from people about the repeat prescription ordering service. In response the team reviewed the procedure for this service. And began photocopying the repeat prescription slip after the person had ticked the medicines they needed. So, the team members could refer to this when the prescription arrived at the pharmacy. And they could show the photocopy to the person when queries arose.

A sample of controlled drugs (CD) registers looked at found that they mostly met legal requirements. Some CD registers were missing the headers. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. But the Responsible Pharmacist notice was displayed in a way that hid the pharmacist's GPhC registration number. Records of emergency supply requests met legal requirements. A sample of records of private prescription supplies found the entries did not always include the date of supply and the date from the prescription. A sample of records for the receipt and supply of unlicensed products looked at found that they did not meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team liaised with the local GP teams after identifying people with early signs of dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The team members support each other in their day-to-day work. And they discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of three full-time qualified dispensers, one who was an accuracy checker, a part-time dispenser, a part-time pharmacy student and a part-time delivery driver. At the time of the inspection the pharmacist manager and three qualified dispensers were on duty. The store manager and assistant store managers gave support to the team throughout the inspection. The pharmacy rotated different tasks amongst the team members. So, everyone could keep their knowledge and skills on how to complete these tasks up to date. And completion of these tasks was not affected by team absence.

The pharmacy provided extra training through e-learning modules. The pharmacy held morning team meetings. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The team had received awards from the company in recognition of the service offered and team leadership. Team members could suggest changes to processes or new ideas of working. The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. 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 large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. And it provides a flu vaccination service popular in the local community. The team members manage the pharmacy services well. They identify risks that may affect the safe delivery of services. And they act to address them. The team members use technology such as scanning bar codes to help make pharmacy services more efficient. The pharmacy team members keep records of prescription requests and deliveries made to people. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

Access to the pharmacy was via a small step. The pharmacy had a temporary ramp to help people enter the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team used a section of the retail area to promote healthy living advice. The latest focus was smoking cessation. The team wore name badges detailing their role. The pharmacy had up-to-date patient group directions (PGDs). These provided the pharmacist with the legal authority to administer the flu vaccine. The flu vaccination service was very popular. Around 700 people had attended the pharmacy since September 2019. A positive message left on Facebook by a person who had received the flu vaccination resulted in 50 people attending the following day. People liked the convenience of the service and the gentle technique used by the pharmacist when administering the vaccine. The team supported the service by taking opportunities when speaking to people to offer the service. And completing the paperwork such as the consent form. This meant the pharmacist had the information to hand before administering the vaccine. And the person was not kept waiting before they received the vaccine. The pharmacy had in-date adrenaline injections in case a person had an anaphylactic reaction to a vaccine.

The pharmacy provided multi-compartment compliance packs to help around 300 people take their medicines. The team members identified they had reached a maximum number of people to provide this service to. So, to take on more people could risk the safe delivery of the service. The team explained this to people asking about the service. And advised the person to return in a few weeks in case circumstances had changed. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team was working to get ahead for the busy Christmas period. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The pharmacy team had worked with the GP team to arrange this timescale. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The pharmacy kept the prescriptions in a dedicated box file so the team could easily find them. The team members used a large dispensing bench at the rear of the dispensary to dispense the medication. And they kept the empty containers the medicines were removed from for the pharmacist to refer to when checking the packs. The team recorded the descriptions of the products within the packs. But a sample of packs looked at found the descriptions were limited to tablets or capsules. A recent computer software upgrade had removed the full descriptions of the products the team had stored on the computer. So, the team members were in the process of updating the computer with the

full descriptions. The team did not always supply the manufacturer's patient information leaflets. The team placed the completed packs in clear bags labelled with the person's name and address. The team used an upstairs room to store the completed packs. And placed the packs in box files on dedicated shelves labelled with the person's name. The delivery driver checked the name on the pack label with the name on the delivery sheet to ensure all packs due out were available. The pharmacy usually received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. The pharmacy team used a company initiative known as Best in Class. This was linked to the management of the multi-compartment compliance packs. And included a weekly tracker listing the people due their medicines. The team members used the tracker to record when they had completed the different stages of processing the packs. The team used a notice board to capture information such as the date a person was admitted in to hospital. And the date the person was discharged from hospital.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And separated people's doses to reduce the risk of selecting the wrong one. The team members provided a repeat prescription ordering service. The team asked the patient to tick against the medicines on the repeat prescription slip. The team used a paper system to remind them when they had to request the prescription. And used this as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The team used the electronic patient record (PMR) to record conversations with people on valproate products or other high-risk medicines such as warfarin. The team recorded information such as when the person had a blood test and what their current dose was. The team generated a list of medicines that were available to supply as an alternative to other versions that were not available at the wholesalers or the manufacturer could not supply. And asked the GPs to contact the pharmacist to discuss the alternative medicines.

The pharmacy used the Well offsite dispensary hub to dispense many of its prescriptions. The team used a programme within the PMR to enter the details from the prescriptions for sending to the offsite dispensary. The team entered the prescription data into the system before sending it to the offsite dispensary. And then marked the prescription kept at the pharmacy to indicate it was being supplied by the offsite dispensary before the pharmacist did a clinical check. The prescription details could not be sent to the offsite dispensary until the pharmacist had done a clinical check. The pharmacist had a password for accessing the system to do the clinical check. This ensured the clinical check was only done by a pharmacist. The pharmacist initialled the prescription to show they had completed the clinical check. The team member placed the prescriptions sent to the offsite dispensary in a box file divided in to the dates the prescription was sent so they could easily find it. The offsite dispensary did not dispense medicines such as controlled drugs and split packs. When the team member accessed the PMR the system issued an alert if the prescription included medicines not dispensed at the offsite dispensary. So, the pharmacy team were aware and would dispense these medicines. The team placed prescriptions split between the offsite dispensary and the pharmacy in a separate section of the box file, so they knew which ones to dispense. The pharmacy had a device that informed the team which stage the prescription was at. So, the team knew if the prescription was being dispensed or on its way back to the pharmacy. The pharmacist manager could cancel the prescription if the person needed their medicines before the prescription came back to the pharmacy. But most prescriptions were repeat prescriptions. And the team gave people the timescale for processing their prescriptions through the offsite dispensary. The offsite dispensary returned the dispensed prescriptions to the pharmacy two to

three days after receiving the prescription. The offsite dispensary sent the medicines in a bag sealed with a bar code. The team members attached the prescription to the bag. And scanned the bar code on the bag and the bar code on the section of shelves that would be holding the completed prescription. The team used this process for prescriptions split between the offsite dispensary and the pharmacy. For example, when the prescription included a controlled drug the team scanned the bar code on the bag with the bar code on the CD cabinet. So, when the team members put the person's name into the scanner, they could see all the storage areas holding the person's completed prescriptions. The team scanned each bag for the person to check they had selected the correct ones. The pharmacy had a text messaging service to inform people when their repeat prescriptions and owings were ready. The pharmacy only sent the text message when it had all the medicines for the person ready for supply. The team had prepared for the new system by sending letters to people informing them that they had prescriptions awaiting collection. So, the team could supply these as soon as possible and not have the two systems operating at the same time.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. And they used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. This included the scanner device the team used to locate completed prescriptions awaiting supply. The scanner alerted the team to prescriptions that had reached the 28-day legal limit or were beyond it. 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 looked at found that the team completed the boxes. The pharmacist marked the prescriptions with CC to show they had been clinically checked it. So, the accuracy checker dispenser could do their check. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with 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. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a 'use this pack first' sticker to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Oramorph oral solution with 90 days used one opened had a date of opening of 08 November 2019 recorded. The team had a template to record fridge temperatures each day. But a sample looked at found on several days in November 2019 the team had not recorded the fridge temperatures. When the team did record the fridge temperatures 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 had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team had not been told when the pharmacy would be FMD compliant. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team 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 protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. And a BP Salter device for measuring people's blood pressure. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team kept the computer screen in the consultation room locked when it was not in use. The team used cordless telephones to make sure telephone conversations were held in private.

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.