General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Alwoodley Pharmacy, 2 The Avenue, Alwoodley, LEEDS, West Yorkshire, LS17 7BE

Pharmacy reference: 1039672

Type of pharmacy: Community

Date of inspection: 20/08/2024

Pharmacy context

This pharmacy is in a large suburb of Leeds. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It supplies many people with their medicines in multi-compartment compliance packs to help them take their medication correctly. And it delivers medicines so several people's home. The pharmacy provides other NHS services including the hypertension case finding service and the Pharmacy First service.

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	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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns. Team members respond competently when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

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

The pharmacy had a procedure for managing errors that occurred during the dispensing process, known as near miss errors. This included the pharmacist and accuracy checking pharmacy technician (ACPT) discussing the error with the team member involved before an entry was made in a near miss record. A sample of records showed details of what had been prescribed and dispensed along with the actions taken to prevent the error from happening again. A separate procedure covered errors that were identified after the person received their medicines, known as dispensing incidents. These were recorded separately and all team members were made aware of the incident. The pharmacist manager reviewed the near miss record and dispensing incident reports each month to identify patterns. The outcome from the review was shared with team members who discussed the actions they could take to prevent these errors from happening again. For example, recent discussions resulted in actions being taken to reduce the risk of errors from team members being distracted. Team members had set up a quiet area for tasks such as dispensing medication into the multi-compartment compliance packs. And to ensure when they were dispensing a prescription, they did not stop the process to answer the telephone. Team members not completing these tasks would answer the telephone and deal with queries. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And a poster in the retail area provided people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The CD registers were kept electronically, and the system captured the current stock balance for each CD register which was regularly checked against the physical stock. This helped to identify issues such as missed entries. The pharmacy kept records of CDs returned by people for destruction. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. And they had been signed by the pharmacist to show they had read them, understood them and would follow them.

Team members had completed training on the General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacy displayed a privacy notice. The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had

completed training relevant to their roles. Team members responded appropriately when safeguarding concerns arose about vulnerable people. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They are encouraged to make suggestions and implement changes to ensure the efficient delivery of pharmacy services. Team members have some opportunities to receive feedback and complete training so they can suitably develop their knowledge.

Inspector's evidence

A pharmacist manager worked full-time with regular locum pharmacist support. The pharmacy team consisted of a full-time ACPT, two full-time dispensers, one part-time dispenser, one full-time trainee dispenser, one full-time medicines counter assistant (MCA), one part-time MCA and a full-time delivery driver. The trainee dispenser had protected time at work to complete their training modules and received support from team members. The pharmacist manager had been in post for a few months and spent time with the previous pharmacist manager before starting in the role.

Team members worked well together and supported each other, especially as the pharmacy had seen an increase in the number of prescriptions it dispensed. Some team members had specific roles such as managing the dispensing of medicines into multi-compartment compliance packs. However other team members were trained to complete these tasks to ensure services were not affected at times of unplanned absence which may impact the team's workload. Additional training for team members was limited to regulatory training, learning from errors, and reading the company newsletter. They received feedback on their performance and were encouraged to use their experience to suggest changes to processes. For example, the ACPT had suggested a more efficient way to store completed prescriptions which was implemented to reduce the risk of the wrong prescription being selected. The ACPT had liaised with the GP team at one surgery where there were problems with the electronic transfer of prescriptions. And discussed how the pharmacy could manage this to prevent delays to people whilst the issue was being addressed.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. Details of the meetings were captured so team members who couldn't attend knew what had been discussed. The pharmacist manager used a recent meeting to remind team members to use the electronic patient record to capture information about a person's medication. Team members used a diary to record key information messages for each other as well as using an online communication platform.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. It has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were a good size and the team kept them tidy and hygienic. There was a clean, well-maintained sink in the area where medicines were prepared. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy maintained its heating and lighting to acceptable levels. And there was sufficient 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. There was a soundproof consultation room which the team used for private conversations with people and when providing services. The pharmacy restricted public access to staff-only areas during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy stores its medicines properly and team members regularly carry out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and a bell attached to the door alerted the team when people entered. Team members provided people with information on how to access other healthcare services. They asked appropriate questions when selling over-the-counter (OTC) medicines and knew when to refer to the pharmacist. The NHS Pharmacy First service was popular, the pharmacist manager met with the local GP teams to advise them of the service and the medical conditions that could be treated. Team members supported the pharmacist by initially assessing the person to ensure they met the criteria for the service. A poster near the pharmacy counter reminded team members of the seven medical conditions that were treated with the service. The pharmacist took opportunities such as people presenting for a one-off prescription to offer them the hypertension case finding service. And had trained team members to identify opportunities to offer the service to people buying OTC medicines. This had resulted in many people having their blood pressure checked and a few referrals to the GP for further checks.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. One of the dispensers managed this service with support from other team members. The dispenser worked in an organised manner, and to manage the workload divided the preparation of the packs across the month. The team ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which team members referred to, alongside the prescription, during the dispensing and checking of the packs. 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. Completed packs were bagged with the prescription token attached and stored on shelves labelled with the person’s name. The pharmacy received copies of hospital discharge summaries via the NHS communication system which the team checked for changes or new items. The team updated the person’s medication list and the electronic record when changes occurred including details of the prescriber making the change.

The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the requirement for valproate to be supplied in the manufacturer’s original packaging. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and reported no-one prescribed valproate met the criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people’s medicines and to help prevent them becoming mixed up. Team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the

pharmacist's clinical check which enabled the ACPT to complete their check. The pharmacy used clear bags to hold dispensed fridge lines, this enabled the team, and the person collecting the medication, to check the supply. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy used an electronic system to record the deliveries due each day and allocate them to the driver via a smart phone App. The team added information such as prescriptions that included a fridge item or a controlled drug. So, the driver knew to ask a team member for these medicines. Team members had access to the system so they could track the driver as they completed the deliveries and check the receipt of the medicine when queries arose. And could see when there had been a failed delivery. When the person was not at home a note was left and the person asked to contact the pharmacy. The same system enabled the team to track the process of dispensing a prescription and to record when people had collected their prescription.

The pharmacy obtained its medication from recognised sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. They checked the expiry dates on stock and marked medicines that were approaching their expiry date to prompt them to check the medicine was still in date when dispensing. No out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records showed the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And 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 via email. The team printed off the alert, actioned it and kept a record. Following an alert involving an incorrect manufacturer's leaflet the team removed the wrong ones and printed out the correct versions to give to people when the medicine was supplied.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. It had a fridge for storing medicines requiring these temperatures which had a glass door so the team could view the stock without prolonged opening of the door. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used a telephone system with cordless option to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.