

Registered pharmacy inspection report

Pharmacy Name: Armley Pharmacy, 62 Armley Ridge Road, LEEDS,
West Yorkshire, LS12 3NP

Pharmacy reference: 1039674

Type of pharmacy: Community

Date of inspection: 07/06/2019

Pharmacy context

The pharmacy is amongst a small parade of shops in Armley, a suburb of Leeds. It dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes.

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. And it keeps most of the records it needs to by law. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't record all errors or review them. This means that the team does not have information to help identify patterns and reduce mistakes. The pharmacy has written procedures that the team follows. But not all the team members have signed to say they have read the procedures. This means there is a risk they may not understand or follow correct procedures.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of pharmacy services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Some team members had read and signed the SOPs signature sheets to show they understood and would follow them. The delivery driver had not signed the SOPs relevant to their role. The SOPs had review dates of 2015. The pharmacist had completed annual reviews but didn't record when this happened. The pharmacy had Indemnity insurance that expired on 24 October 2019.

On most occasions the pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake, rather than getting them to find it themselves. The pharmacy had a log to record these errors, but the last entry was in 2016. The pharmacist discussed regular errors with the team. And had highlighted frequent errors involving amitriptyline and amlodipine. The pharmacy had a template to record dispensing incidents. No completed forms were available to look at. The team members had bought large baskets to use when dispensing prescriptions with several medicines. The team members introduced this following an error when they had supplied one person's medication to someone else. The team identified the cause of the error was overflowing baskets.

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. A recent survey included a comment about the limited services offered. As a result, the pharmacist was planning to introduce the flu vaccination service. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. Some registers were not attached to the folder holding them which ran the risk of losing them. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they mostly met legal requirements. But the time the pharmacist signed out as the Responsible Pharmacist was not always recorded. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacist had discussed the requirements of the General Data Protection Regulations (GDPR) with the team. The pharmacy had a folder containing GDPR information that the team had read. The pharmacy didn't display a privacy notice in line with the requirements of the GDPR. The pharmacy displayed details on the confidential data kept and how it complied with the Data Protection Act and the NHS Code of Confidentiality. The team separated confidential waste and shredded it onsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The driver reported to the team any concerns he had about people he delivered medication to. The team shared these concerns with the person's GP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to support the pharmacy's services. And they share information and learning particularly from errors when dispensing. The pharmacy team members have some opportunities to complete more training. But they don't receive feedback on their performance. So, they may miss the opportunity to reflect and identify training needs. And progress in their role or take on a new role to help the safe and effective delivery of services.

Inspector's evidence

The Superintendent Pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of one dispenser, a trainee dispenser and a delivery driver. At the time of the inspection the Superintendent Pharmacist and the trainee dispenser were on duty. The trainee dispenser was halfway through completing the course though they had started it sometime ago. The pharmacist explained that due long-term sickness the course provider had advised the trainee to re-start the course.

The pharmacy provided extra training through reading materials from pharmacy organisations. And the team members attended local training events. The pharmacy held meetings when the team discussed various matters. The pharmacy didn't provide the team members with formal performance reviews. This meant that they missed out on opportunities to receive feedback and discuss development needs. The pharmacy did not set targets for the services offered.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was hygienic. It had separate sinks for the preparation of medicines and hand washing. The team usually 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 consultation room. The team used this for private conversations with people. The room was cluttered with boxes. The team used cordless telephones to make sure telephone conversations were held in private.

The premises were secure. There was restricted access to the dispensary during the opening hours. 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 provides services that support people's health needs. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines appropriately. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. But the team does not always supply information leaflets with medication to help people take their medicines safely.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy had a door bell for people to use to alert the team for help getting into the pharmacy. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a large range of healthcare information leaflets for people to read or take away.

The pharmacy provided multi-compartmental compliance packs to help 30 people take their medicines. One of the qualified dispensers managed the service. And received support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team usually used an upstairs room to dispense the medication. This was away from the distractions of the main dispensary and gave more space to do this task. The team kept the empty containers used for dispensing with the completed packs. The pharmacist referred to the empty containers when checking the packs. The pharmacy recorded the descriptions of the products within the packs to help people identify the medicines. But it did not always supply the manufacturer's patient information leaflets. The team stored completed packs in baskets labelled with the person's name and address. And kept these baskets on dedicated shelves in the upstairs room. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. And shared the discharge summary with the GP team with a request for prescriptions when required. The team managed changes to packs already sent to people by getting them back and making the amendments. Or the team sent enough medication to cover until the next pack was supplied. The team updated the medication list to show when changes had occurred and who had asked for them.

The pharmacy supplied methadone as supervised and unsupervised doses to two people. And it prepared the methadone doses 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.

The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions four days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team kept an electronic record of requests and regularly checked it to

identify missing prescriptions. The team chased up missing prescriptions with the GP teams. The pharmacy team kept people's repeat prescription slips in a box divided in to the days of the month. This helped to easily locate the form when ordering the next prescription. The pharmacy also kept people's repeat slips to order their medicines when they telephoned the pharmacy. The pharmacy stored these slips in a box in alphabetical order. The pharmacy team had completed checks to identify people that met the criteria of the valproate Pregnancy Prevention Programme (PPP).

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. 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. 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 usually completed the boxes. 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 kept a record of the delivery of medicines to people. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. But didn't keep a record of this. The team used a coloured dot to highlight medicines with a short expiry date. And it kept a list of products due to expire each month. 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 three months use once opened had a date of opening of 24/04/19 recorded. The pharmacy kept electronic records of the daily fridge temperature readings. A sample looked at found they were within the correct range. But the thermometers at the time of the inspection were showing maximum temperatures outside the range. The team members were monitoring this. 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 scanning equipment to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 09 February 2019. The pharmacy did not have an SOP to cover this activity. 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 protect people's private information. Reference sources are available for the pharmacy team to ensure they have ready access to up to date clinical 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 marked equipment to accurately measure liquid medication. And used separate, labelled measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures.

The computers were password protected and access to peoples' 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.

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.