General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 275 Burley Road, LEEDS, West Yorkshire, LS4 2EL

Pharmacy reference: 1039679

Type of pharmacy: Community

Date of inspection: 23/11/2023

Pharmacy context

This pharmacy is next door to a large medical centre in a suburb of Leeds. It dispenses NHS prescriptions. And it supplies several people with their medicines in multi-compartment compliance packs to help them take their medication properly. The pharmacy provides other services including the seasonal flu vaccination service and the NHS hypertension case finding service. The pharmacy uses the company's offsite hub pharmacy to assemble some of its prescriptions.

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 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. Team members suitably protect people's confidential information, and they clearly understand their role to help protect vulnerable people. The team members respond appropriately 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 were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. Team members accessed the SOPs through personal log-in numbers. And completed a quiz connected to each SOP to show they had read, understood and would follow the SOP. The pharmacist manager had access to all team members accounts so could monitor their progress in completing them. And was advised of new SOPs and amendments to existing ones. 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 identified during the dispensing of prescriptions, known as near miss errors. The team member involved was asked to identify their error, correct it and record it on an electronic platform. A sample of records showed team members' reflections and learnings from the error to help prevent similar errors from happening again. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. And team members discussed how to prevent such errors from happening. Errors with medicines dispensed at the offsite dispensing hub were recorded and reported back to the team at the hub. The pharmacist manager regularly reviewed the near miss errors and dispensing incidents. And shared the outcome from the review with team members, who discussed the changes they could make to prevent errors. The outcome from a recent review was used to remind team members to ensure clear dose instructions were printed on the dispensing label. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the company's website 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, private prescriptions 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. A random balance check undertaken during the inspection was correct.

Team members knew how to manage people's confidential information and the pharmacy displayed a privacy notice. Confidential waste was separated and shredded offsite. The pharmacy had safeguarding procedures and training relevant for each team member. Team members responded appropriately when they identified safeguarding concerns.

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 are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the effective delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy technician, one full-time dispenser, one part-time dispenser and a part-time delivery driver. Team members worked well together and experienced team members were encouraged to use their knowledge and skills to support the team. Some team members had specific tasks, but they had regular opportunities to work in other areas such as the pharmacy counter to help them maintain their skills.

Team members used company online training modules to keep their knowledge up to date and they had protected time at work to complete the training. The training ranged from mandatory learning such as data protection to subjects that a team member had a specific interest in learning about. For example, one of the dispensers had completed training about eczema after identifying people often asked for recommendations on creams they could use.

Team members received formal performance reviews so they could identify opportunities to develop their knowledge and skills. The pharmacy regularly held team meetings and the pharmacy manager shared relevant information from the meetings they had with other managers. Team members could suggest changes to processes or new ideas of working. The pharmacy technician had shared an idea from a previous role for keeping the GP team updated with information on the availability of medicines. This was agreed and regular emails were sent informing the GP team of medicines that were in short supply along with information on alternative medication that could be prescribed. This also helped to reduce concerns from people about problems receiving their medication. And they were not left waiting for an alternate prescription to be generated.

The pharmacy had targets for some services such as the NHS hypertension case finding service. The pharmacist manager reported the targets were manageable and the services were offered when they would benefit people and improve their health.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy team kept the premises tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, and alcohol gel was also available for hand cleansing. 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 had enough 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. The pharmacy had a soundproof consultation room which the team used for private conversations with people and when providing services such as the flu vaccination. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a 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 obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a small step. And people could use a doorbell to attract team members attention for help with accessing the pharmacy. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the correct product was supplied. And they knew when to refer requests to the pharmacist.

The pharmacy provided the seasonal flu vaccination service against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to administer the vaccine. The pharmacist had easy access to adrenaline injections in the event of a person having an anaphylactic reaction to the vaccine. The hypertension case finding service was popular and had resulted in some people being referred for further tests. When the initial blood pressure readings indicated the person needed to use a 24-hour BP monitor the pharmacist explained how it worked and the importance of using it. This was particularly important when people raised concerns about the impact of wearing the monitor for this length of time.

The pharmacy sent several prescriptions to the Well offsite hub pharmacy to be assembled there. Before sending the prescription information, the team processed the prescriptions, and the pharmacist completed a clinical check. Some medicines such as CDs and items the person urgently needed were dispensed at the pharmacy to reduce risk and ensure people’s medicines were ready when they needed them. Most dispensed prescriptions from the hub were returned to the pharmacy the following day. They were supplied in a sealed bag with an embedded bar code, which the team scanned to confirm receipt. Team members matched any prescriptions dispensed at the pharmacy with prescriptions for the same person sent from the hub. And they used the bar code scanning technology to locate where all the completed prescriptions for a person were held. This ensured people received all their medicines. Random checks of the dispensed prescriptions sent from the hub were completed as part of governance procedures. Any errors identified were recorded. The team reported there very few occasions when there were issues with the prescriptions dispensed at the hub.

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. To manage the workload the team divided the preparation of the packs across the month. And prescriptions were generally issued as electronic repeat dispensing prescriptions. The team requested other prescriptions one week before the packs were dispensed, to give time to manage queries. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of prescriptions. The team checked the prescriptions sent to the pharmacy against the list to spot any changes to the medications prescribed. And to identify any

medicines that were supplied separately to the packs such as inhalers. The person was contacted to ask if they needed these medicines before the packs were supplied. The records also included a section to record changes and the outcome from queries. For example, a prescription for a person on a reducing dose of medication had not been amended to reflect this. The packs for this person were clearly marked to indicate a new prescription had been requested. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries via the NHS communication system which the team checked for changes and new items. The team had a good working relationship with the team at the nearby medical centre. So, changes to people's medication were quickly shared and new prescriptions promptly sent. To cover the busy Christmas period the team was working in advance to prepare several packs together.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And were stored securely in baskets labelled with each person's name.

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). They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and they supplied valproate in original packs. The team 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. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy had a system to ensure prescriptions with CDs were supplied within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy sent people a text message to advise them when their prescription was ready to collect. And it kept a record of the delivery of medicines to people for the team to refer to when queries arose. Team members liaised with people requesting the delivery service to agree a suitable day for them to receive their medication, which helped to prevent failed deliveries. They kept a record of when the deliveries were due to ensure the prescriptions were ready for the driver to collect. If the person was not at home the delivery driver left a note informing the person of the failed delivery. And returned the medication to the pharmacy where it was stored in a dedicated section. So, the team could easily find it if the person came to collect it.

The pharmacy obtained medication from several reputable sources and team members followed procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were marked to prompt the team to check the medicine was still in date. 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. They checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it securely stored out-of-date, and patient returned CDs. 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 (MHRA) via the company communication platform. The team responded appropriately to these alerts and kept a record of their actions.

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 references sources and access to the internet to provide the team with up-to-date information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And a large fridge for holding medicines requiring storage at this temperature. The fridge had a glass door that enabled the team to view stock without prolong opening of the door. The pharmacy completed safety checks on the electrical equipment.

The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used cordless telephones 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.