

Registered pharmacy inspection report

Pharmacy Name: Star Pharmacy, 136 Cardigan Road, LEEDS, West Yorkshire, LS6 1LU

Pharmacy reference: 1039710

Type of pharmacy: Community

Date of inspection: 16/01/2020

Pharmacy context

This community pharmacy is on a busy road in a suburb of Leeds popular with students. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service. And it provides the emergency hormonal contraception (EHC) service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.3	Standard not met	The pharmacy doesn't manage and store all its medicines appropriately. Pharmacy team members remove medicines from their original blister packaging. They don't store these medicines appropriately. And they don't label alternative containers appropriately. This includes no batch number and expiry date. So, the team doesn't know if these medicines are fit to supply. Or if they have been the subject to a medicine recall.
5. Equipment and facilities	Standards not all met	5.3	Standard not met	Pharmacy team members use mobile telephones to temporarily store some people's confidential information. This information is not stored securely. So, there is a risk of unauthorised access to people's private information.

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy team mostly identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. And team members respond to feedback provided by people. Some team members have training, guidance and experience 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 take the action needed to help prevent similar errors happening again. But they don't fully record all their errors. So, the team does not have all the information available to help identify patterns and reduce errors. The pharmacy has some procedures to protect people's confidential 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 SOPs were provided by the Numark organisation but did not include the name of the pharmacy. Each SOP listed the role within the team the SOP was relevant to. A few team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. The pharmacy pre-registration student in post one month, the part-time dispenser, the delivery driver, the Superintendent Pharmacist and one of the pharmacist owners had not signed the SOPs. The team members had a clear understanding of their role and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary. 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 error. The pharmacist discussed the error with the team member involved to identify what caused the error. And how to prevent the error from happening again. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. The records captured the cause of the error. But many entries had the same details recorded. The entries stated the cause was a lack of concentration when dispensing. So, there was little evidence of individual reflection by the team member involved of why the error happened. The entries showed a variety of actions to prevent the error happening again. Examples of the action taken to prevent the error included double checking the quantity of medicine dispensed. And checking the expiry date of the medicine. The Superintendent Pharmacist reviewed these records to spot patterns and make changes to processes. The pharmacist shared the results of the review with the team but didn't keep a record of the review. The pharmacist had highlighted to the team common errors involving allopurinol 100mg and atenolol 100mg. And the team had separated the two products. The pharmacist recorded dispensing incidents on to the person's electronic medication record (PMR). These were errors identified after the person had received their medicines. The details captured on the records were limited. There was no record of what caused the error and the actions taken by the team to prevent the error happening again.

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. But the poster was displayed high on the wall behind the pharmacy counter. So, it was difficult for many people to read the information on the poster. The pharmacy team used surveys to find out what people thought about the pharmacy. The results were published on the NHS.uk website. And on the wall behind the pharmacy counter. So, they were not in clear view for people to read. The pharmacy had responded to comments about the waiting area by increasing the number of chairs available.

A sample of Responsible Pharmacist (RP) records looked at found there were no entries on two days. Several entries did not have the RP's GPhC registration number and the times the RP was on duty or stopped being on duty. Incomplete and missing RP records were found at the last inspection in May 2018. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked most CD stock against the balance in the register. This helped to spot errors such as missed entries. But the pharmacists did not check the methadone balances. The pharmacy recorded CDs returned by people. 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 team members could not recall if they had received training on the General Data Protection Regulations (GDPR). The pharmacy did not display details on the confidential data kept and how it complied with legal requirements. The team placed confidential waste into a separate marked bin and removed it for offsite shredding. 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. Only one team member had completed Dementia Friends training. The team responded appropriately when safeguarding concerns arose.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. It gives team members regular feedback on their performance and provides some extra training. So, they can identify what they do well and keep their skills up to date. The pharmacy offers team members opportunities to develop their career. And it supports team members who take on new roles. The team members support each other in their day-to-day work. And they discuss their errors and how they can prevent them from happening again to support the safe and effective delivery of pharmacy services.

Inspector's evidence

The Superintendent Pharmacist and one of the pharmacist owners covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pharmacy pre-registration student, two full-time dispensers, two part-time dispensers and delivery drivers. One of the full-time dispensers was the pharmacy manager. And had been in post a few months. The dispenser had expressed an interest in the manager's role. So, when the previous manager left the pharmacist owners asked the dispenser if they wanted to take on the role. The Superintendent Pharmacist and pharmacist owner supported the dispenser as they developed their understanding of the role and the skills needed to be a manager. At the time of the inspection the Superintendent Pharmacist, the pharmacy manager and two of the dispensers were on duty.

The pharmacy held weekly team meetings when information such as dispensing incidents were discussed. And it used a WhatsApp group to ensure all team members had up-to-date information. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had taken the opportunity to ask about training to be a pharmacy technician. This dispenser was recently appointed as the pharmacy manager. And had agreed to wait to do the pharmacy technician training as they developed the manager's role. The pharmacy provided limited opportunities for the team undertake extra training. The training available included information provided by manufacturers about new products or information from pharmacy magazines. Team members could suggest changes to processes or new ideas of working. The pharmacy had some targets for the services offered. The pharmacy team offered the services when they would benefit people.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are 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 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 sound proof consultation room. The team used this for private conversations with people. The pharmacy had a large pharmacy counter. This provided the team with space to speak privately to people who did not want to use the consultation room. 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 not all met

Summary findings

The pharmacy provides services that support people's health needs and it mostly manages its services appropriately. The pharmacy obtains its medicines from reputable sources. But it does not store all medicines appropriately. So, there is an unmanaged risk the pharmacy may supply medicines that are out of date or not fit for purpose. The pharmacy delivers medicines to people's homes. But the driver doesn't always obtain signatures from people for the receipt of their medicines. So, the pharmacy doesn't have a robust audit trail and cannot always evidence the safe delivery of people's medicines. The pharmacy team takes care when dispensing medicines in to multi-compartment compliance packs to help people take their medication. And it keeps its records about people's prescription collection requests up to date. So, this enables the team to deal with any queries effectively.

Inspector's evidence

People accessed the pharmacy via a ramp and steps with handrails. And through a power-assisted door. 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 pharmacy had up-to-date patient group directions. These provided the pharmacists with the legal authority to deliver services such as Emergency Hormonal Contraception (EHC). One person using the EHC service complained that the pharmacist had not provided the information leaflet. Following this incident, the pharmacists gave the leaflet to the person during the consultation. And highlighted the key pieces of information. So, the person could read the information and ask any questions before leaving the pharmacy. The pharmacy had a procedure and a flowchart displayed in the dispensary detailing the steps to follow when providing the Community Pharmacist Consultation Service (CPCS).

The pharmacy provided multi-compartment compliance packs to help around 108 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions a 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 pharmacy received some prescriptions as part of the electronic repeat dispensing service and several prescriptions were received close to the date of supply. To manage the risk of dispensing the prescriptions in a rush the team prepared four weeks packs against the first prescription and the medication list. The pharmacist completed a check of the packs. And the team stored the packs in baskets on a dedicated set of shelves awaiting the prescription. Once the prescription arrived the team moved the baskets to a different set of shelves awaiting the pharmacist final check. The team kept a record of when the pharmacist completed the first and final checks of the packs. And when the team placed the packs in to the box for delivery. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The team stored completed packs in box files labelled with the person's name and address. The GP teams informed the pharmacy team of changes to people's medicines by fax and a telephone call. 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 sent a copy to the person's GP with a request for a prescription when required.

The pharmacy provided compliance packs to several homes of varying sizes. The pharmacy team

ordered the medicines for the care homes. The care home teams marked the repeat prescription slips to indicate the medicines required and sent the slips to the pharmacy team to send to the GP. But the care home teams did not send the pharmacy team a separate record of the medicines ordered. So, the pharmacy team did not know what medicines were missing when the prescriptions arrived at the pharmacy. The team ordered the prescription for the care home packs two weeks before supply. And sent the packs to the care home five days before the next cycle started. This gave the care home team time to check the medicines supplied and chase up any missing medicines.

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. But it did not separate people's doses to reduce the risk of selecting the wrong one. The pharmacist marked the lid on the bottle containing the methadone dose with the person's initials. But some people had the same initials. The pharmacist checked the dose against the prescription at the point of supplying to the person.

The team members provided a repeat prescription ordering service. They used a spreadsheet to record when they had to order the prescription and the spreadsheet was divided into weeks one to four. 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 regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team sent people who ordered their own prescriptions a text message to remind them to order their medicines. The team used the text messaging service to pass 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). And the pharmacy had a SOP for supplying valproate to people requiring a PPP. The pharmacy had completed checks to identify patients who may meet the PPP criteria. And found no-one prescribed valproate met the PPP criteria. The team asked people on high-risk medicines such as warfarin about their last blood test and dose. But the team did not keep records when people provided this information.

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 attached the bag label to the front of the basket holding dispensed items awaiting the pharmacist check. And stored the baskets on dedicated shelves. So, they could easily find the prescription if the person presented before the pharmacist had completed the check. And give it to the pharmacist to complete the check. The pharmacy used controlled drug (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 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 used the text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. But this was only for CD deliveries. So, the pharmacy didn't have a full audit trail or proof of delivery for all prescriptions.

Several tablets bottles containing loose medicines were found on the shelves in the dispensary. The tablet bottles were only labelled with the name of the medicine. The batch number and expiry date of

the medicines were not recorded on the label. So, the team could not check these medicines against any safety alerts that came through. And the team couldn't include these medicines in any date checks. A few boxes were found containing loose tablets popped out from the manufacturer's foil. These were in the manufacturer's original pack which had the batch number and expiry date. But the medicines were not protected from the effects the pharmacy environment may have on the medicines removed from the original packaging. And the team could not ensure the quality of the medicines after storing them outside of the manufacturer's packaging. This also ran the risk of losing the medicines. The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was in December 2019. The team highlighted 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. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. The pharmacy recently installed another CD cabinet. And used the additional cabinet to store out-of-date CD stock and patient returned CDs awaiting destruction. The team used appropriate denaturing kits to destroy CDs. The team stored CD prescriptions waiting for the pharmacist to check in dedicated baskets in the CD cabinet.

The pharmacy had a procedure detailing the requirements of the Falsified Medicines Directive (FMD). And equipment for FMD. But the team members were not scanning FMD compliant medicines. 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 not all met

Summary findings

The pharmacy has the equipment it needs to provide safe services. The team mostly uses the pharmacy's facilities and equipment in a way to protect people's private information. But the team members use mobile telephones to temporarily store some people's confidential information. This information is not stored securely on the mobile telephones. So, there is a risk of unauthorised access to 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. One fridge had a glass door that allowed the viewing of stock without the door being open for a long time. The team used baskets to separate the fridge stock. And labelled the baskets to show what items were in the basket. The team used one fridge for stock and checked prescriptions awaiting delivery. The team used the other fridge for prescriptions waiting to be checked and checked prescriptions awaiting collection by the person.

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 team used cordless telephones to make sure telephone conversations were held in private. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. A CD register containing people's confidential information was found on a shelf in the consultation room. The pharmacy team took photographs of the repeat prescription slips used by the care homes team to order medicines for people living in the care home. And kept the photographs on the pharmacy WhatsApp group. The team members took the photographs before sending the repeat prescription slips to the GP team so they could order the medicines before the prescription arrived. The team also used the photographs to check that the medicines on the prescription matched the items requested by the care home teams. The team deleted the photograph from the phone once the prescription arrived. The pharmacy team did not know if the photograph on the phone that included people's confidential information was protected from unauthorised access. The pharmacy team members stated they took the photographs because the care home teams did not send the pharmacy a list of the medicines they had ordered. A discussion was held with the team about asking the care home teams for a list of the medicines they had ordered. So, the pharmacy team did not need to take photographs of the repeat prescription slips.

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.