General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 29 High Street, Yeadon, LEEDS, West Yorkshire, LS19 7SP

Pharmacy reference: 1039744

Type of pharmacy: Community

Date of inspection: 25/10/2023

Pharmacy context

This community pharmacy is in the centre of Yeadon a large town in Leeds. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It supplies several people with their medicines in multi-compartment compliance packs to help them take their medication properly. The pharmacy provides the seasonal flu vaccination service and delivers medication to people's homes.

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	2.2	Good practice	The team members work very well together, and they are good at supporting each other in their day-to-day work. They discuss ideas to enhance the safe delivery of the pharmacy's services. And they identify any impact on their workload from changes to roles within the team. Team members are encouraged to take on new roles and responsibilities to support the delivery of the pharmacy's services. And it encourages experienced team members to train colleagues for these roles.
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 written procedures that the pharmacy team follows and it completes 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, they discuss what happened and take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team members with information to perform tasks supporting the delivery of the pharmacy services. The SOPs were kept electronically which each team member accessed through personal logins. They answered a few questions related to each SOP to demonstrate they'd understood the SOP and would follow it. Team members were advised of new and updated SOPs and the pharmacist manager monitored their progress with reading and signing off the SOPs. They 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. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were advised of the dispensing incident, and they discussed the changes they could make to prevent future errors. An electronic record of the dispensing incident was kept. When patterns emerged with errors the team acted to reduce the risk of them happening again. For example, venlafaxine capsules and tablets were separated on the shelves and prominent labels attached to each shelf to prompt team members to check the medication they'd selected. Team members stored completed prescriptions for people with similar surnames on different sections to reduce the risk of picking the wrong one. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And a leaflet displayed in the retail area provided people with information on how to raise a concern with the pharmacy team.

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. A random balance check undertaken during the inspection was correct. The pharmacy displayed details on the confidential data it kept and how it complied with legal requirements. It also displayed a separate privacy notice. The team members completed training about the General Data Protection Regulations (GDPR). And they separated confidential waste in a dedicated container for shredding 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. The team members work very well together, and they are good at supporting each other in their day-to-day work. They discuss ideas to enhance the safe delivery of the pharmacy's services. And they identify any impact on their workload from changes to roles within the team. Team members are encouraged to take on new roles and responsibilities to support the delivery of the pharmacy's services and they have opportunities to receive feedback.

Inspector's evidence

A full-time pharmacist manager covered most of the pharmacy's opening hours with locum pharmacist cover for the remaining hours. The pharmacy team consisted of one full-time dispenser, a part-time dispenser who was training to be an accuracy checker (ACDA), a part-time dispenser and a full-time trainee dispenser. Another trained dispenser was on long-term absence. The trainee dispenser and trainee ACDA had little protected time at work to complete their training. However, the trainee dispenser was supported by other team members. The trainee ACDA had arranged time with the pharmacist manager to complete their training, particularly the final section involving the accuracy checking of several prescriptions. All team members were trained on how to undertake key tasks and a team rota ensured these tasks were completed each day.

At the time of the inspection all team members except the part-time dispenser were on duty. However, during most of the inspection only one dispenser was working in the main part of the pharmacy with the pharmacist. The other dispenser was upstairs preparing the multi-compartment compliance packs. On several occasions a queue of people developed as the pharmacist was providing the flu vaccination and the dispenser was managing telephone queries. The pharmacist manager reported the team had experienced an increase in workload especially with dispensing NHS prescriptions as other pharmacies in the area closed or reduced their hours. And the team hours had been impacted by unplanned absences. This resulted in team members who usually worked during the week using some of their contracted hours to cover the Saturday morning opening hours. The team members supported each other but they often worked under pressure especially at times when only the pharmacist and one team member were working together. This often led to queues developing which several people had been unhappy about and raised this directly with the team. On such occasions the team members supported each other and offered people the opportunity to use another pharmacy. The pharmacist manager reported there had recently been a change of ownership at the other pharmacies and some people were returning to these pharmacies. And this had resulted in the team noticing some decrease in its workload.

The trainee ACDA and the part-time dispenser had worked well together to manage the large number of multi-compartment compliance packs. This included allocating an extra day for the preparation of the packs before the person needed the supply so they could manage unexpected disruptions to the team. The preparation of weekly supplies of packs had also changed to enable the team to manage changes to the packs and the volume of weekly packs supplied.

Team members used company online training modules to keep their knowledge up to date. But they didn't have protected time at work to complete the training. The trainee ACDA had trained team members who had previously worked at other pharmacies on the systems and processes at this

pharmacy. The team recognised that once the ACDA had qualified they wouldn't always be involved in the dispensing of prescriptions. So, the ACDA was training other team members on the processes for ordering and labelling prescriptions for the multi-compartment compliance packs. The team held regular meetings and used an online communication platform to keep all team members up to date with changes. The newsletter from the area manager was shared with the team to read. Team members received formal feedback on their performance from the pharmacist manager and discussed learning and development opportunities.

The pharmacist reported some pressures to undertake NHS services such as the Hypertension Case Finding Service. But due to the increased dispensing workload and reduced team hours they had not been able to regularly offer these services. Some team members regularly contacted the area manager to share concerns and their ideas on how to manage the teams' workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable 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 premises were tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room did not contain a sink but alcohol gel was 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. Some storage areas needed repair such as a set of drawers in the dispensary that were missing the front sections. 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 entrance to the room was via the side of the pharmacy counter and the entrance to the dispensary. The team ensured there was no confidential information on view to the person as they passed this area. 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 and help people to meet their healthcare needs. Team members manage the pharmacy services well to make sure people receive their medicines when they need them. They generally store medicines properly and they check to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free access. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. And it kept a small range of healthcare information leaflets for people to read or take away. Team members provided people with information on how to access other healthcare services when required and they wore name badges so people knew who they were speaking to. The pharmacy provided the flu vaccination against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the authority to administer the vaccine.

The pharmacy sent several prescriptions to the Well offsite dispensary hub. The team processed the prescriptions, and the pharmacist completed a clinical check of the prescriptions before the prescription data was sent to the hub for dispensing. 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. The team reported the number of prescriptions dispensed locally had increased as people's repeat prescriptions were not always ordered in time. Most dispensed prescriptions from the hub were returned to the pharmacy the following day. And supplied in a sealed bag with an embedded bar code, which the team scanned to confirm receipt. The team members stored the completed prescriptions from the hub separately to medicines dispensed at the pharmacy. And they used the bar code scanning to locate where all the completed prescriptions for a person were held to ensure all their medicines were handed over.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. A large upstairs room was used for dispensing and storing the packs, this was away from the distractions of the main dispensary. To manage the workload the team divided the preparation of the packs across the month. And they ordered prescriptions several days 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 during the dispensing and checking of prescriptions. One team member checked the received prescriptions and labelled them which triggered an order for the medicines. Another team member dispensed the medicines into 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. Team member clearly separated monthly supplies of packs from weekly supplies.

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. The pharmacy stored the prepared doses securely with some separation between people's doses.

Team members provided people with clear advice on how to use their medicines. They were aware of

the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. And they supplied valproate in original packs. The team 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. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. And clear bags were used to hold dispensed CDs and fridge lines to allow 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. 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.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock but didn't always keep a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date, no out-of-date stock was found. The dates of opening were usually recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines were still safe to use. However, an opened bottle of carbocisteine with one month used once opened did not have a date of opening recorded. The team 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 email. The team responded appropriately and kept a record.

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. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And fridges for holding medicines requiring storage at this temperature. The fridges had glass doors that enabled the team to view stock without prolong 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 positioned the dispensary computers in a way to prevent disclosure of confidential information. And they stored completed prescriptions away from public view. The pharmacy 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.