General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Andrew Tylee Ltd.;, 25 Hyde Park Road, LEEDS, West Yorkshire, LS6 1PY

Pharmacy reference: 1039751

Type of pharmacy: Community

Date of inspection: 04/07/2019

Pharmacy context

The pharmacy is amongst a parade of shops in a large 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 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 not all met	1.2	Standard not met	The pharmacy has written procedures for managing dispensing incidents. But the pharmacy team does not follow the procedures. The team does not keep records when things go wrong. And there are no arrangements for the pharmacy team members to report and learn from their own errors. So, they do not have the information to identify patterns and help reduce similar mistakes in the future.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.2	Standard not met	The room in the pharmacy used for people to have confidential conversations with the pharmacy team does not protect people's privacy.
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 not all met**

Summary findings

The pharmacy identifies some of the risks associated with its services. The pharmacy has adequate arrangements to protect people's private information. But the taxi driver who delivers medicines to people at home has not received training or read the documents provided by the pharmacy on handling confidential information. The pharmacy has written procedures for the team to follow. But they have not been recently reviewed. And the taxi driver who delivers medication to people's homes has not signed to confirm they have read them. This means there is a risk that team members may not understand or follow correct procedures and the procedures may be out of date. The pharmacy has written procedures for managing dispensing incidents. But the pharmacy team does not follow the procedures. The team does not keep records when things go wrong. And there are no arrangements for the pharmacy team members to report and learn from their own errors. So, they do not have the information to identify patterns and help reduce similar mistakes in the future.

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 services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs had review dates due in September 2018. But the pharmacy hadn't completed the review. Most of the team had read and signed the SOPs signature sheets to show they understood and would follow them. The taxi driver delivering medicines to people's homes had not read the SOPs. The pharmacy had up to date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. So, the team members didn't have the opportunity to identify their own errors. The pharmacy had written procedures that required the recording of the errors. But, the pharmacy team did not record these errors. So, the team did not have information to help spot patterns and make changes to processes. The pharmacist stated there were no patterns from the errors picked up. And the team had no examples of changes made to prevent errors. The pharmacy team had procedures for recording dispensing incidents. This included a template to record dispensing incidents. The pharmacist had not recorded a recent error about the supply of the wrong strength of propranolol. The pharmacy didn't have evidence to show it had completed reports for other dispensing incidents.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a notice providing people with information on how to make a complaint. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy displayed them in the retail area.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies met legal requirements. A sample of records of emergency supplies of medication found that the reason for the supply was not always recorded. A sample of records for the receipt and supply of unlicensed products looked at found that they usually met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy had a folder containing documents about data security and protection. There was no evidence that the team had read the documents including the taxi driver who delivered people's medicines. The team had not received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. And it displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. About four years ago the pharmacist had completed from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had not completed Dementia Friends training. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team and the team members have the skills to support the pharmacy's services. But they receive little feedback on their performance. So, they may miss the opportunity to set personal objectives or complete training plans to help the safe and effective delivery of pharmacy services.

Inspector's evidence

The pharmacist owner and regular locum pharmacists covered the opening hours. The pharmacy team consisted of two dispensers and a trainee dispenser. The trainee dispenser had started this training eight years ago. Due to personal circumstances and delays with the pharmacist signing off the modules, the trainee had not completed the course. At the time of the inspection the pharmacist owner, one of the qualified dispensers and the trainee dispenser were on duty.

The pharmacist attended training events ran by the Informacist organisation. The pharmacy did not provide the team with additional training. The pharmacy did not undertake performance reviews with the team. So, they didn't have a chance to receive feedback and discuss development needs. Such as the trainee dispenser setting a goal to compete their training. Team members could suggest changes to processes or new ideas of working. The pharmacy had no targets for services such as Medicine Use Reviews (MURs).

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean, secure and suitable for the services provided. The room used for people to have confidential conversations with the pharmacy team does not protect people's privacy.

Inspector's evidence

The pharmacy was clean and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room didn't contain a sink. But the pharmacy had alcohol gel for hand cleansing. 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 consultation room that led from the retail area. The team used this for private conversations with people. The room had a small window looking into the retail area. The window did not have any cover. So, people in the retail area could see anyone in 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 met

Summary findings

The pharmacy provides services that support people's health needs. And it adequately manages its services. The pharmacy gets its medicines from reputable sources. And it generally stores and manages its medicines appropriately. Although its team members do not always supply information leaflets with medication to help people take their medicines safely. The pharmacy keeps its records about prescriptions and deliveries up to date. And this enabes it to deal with any queries effectively.

Inspector's evidence

People accessed the pharmacy via steps or a ramp, both with handrails. And through an automatic door. The pharmacy had an information leaflet for people to read and take away that focused on different health matters each month. The leaflet also contained the contact details of the pharmacy and opening hours. Recent topics included healthy eating. 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 provided multi-compartmental compliance packs to help around 86 people take their medicines. The team managed the workload by dividing the preparation of the packs across the month. The team had a list of people who received packs and when the person collected the pack. The team usually received and obtained the prescriptions in advance of supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Most prescription were sent electronically and, in the repeat dispensing format. A few GP teams sent the prescriptions close to the time of supply. The team knew about these prescriptions so made sure they had capacity to prepare the packs. The team members did not record the descriptions of the products within the packs to help people identify their medicines. And they did not always supply the manufacturer’s patient information leaflets. The team stored completed packs on top of each other on dedicated shelves. The team didn’t separate different peoples' packs to reduce the risk of picking the wrong person’s pack. 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. The GPs teams sent faxes to the pharmacy detailing any required changes.

The pharmacy supplied methadone as supervised and unsupervised doses. 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 pharmacy provided a repeat prescription ordering service. The team used a diary to record when they had requested the prescription. And used this as an audit trail to track the requests. The pharmacist and pharmacy team delivered medicines to people’s homes. The pharmacy also used a taxi driver to deliver the medicines. The pharmacy used the same taxi driver, so people recognised him. The driver was not employed by the pharmacy. And had not received any training or read the pharmacy’s written procedures to ensure the driver was following the correct process for the safe delivery of medicines. The pharmacy team generated a list of people due to have their medicines delivered each day. The pharmacy obtained a signature from the person receiving the medication. And the taxi driver returned any medicines to the pharmacy when the person was not at home.

The pharmacy team had not completed checks to identify any people meeting the criteria of the valproate Pregnancy Prevention Programme (PPP). The team members stated that they were not aware of anyone prescribed valproate products that met the criteria. The pharmacy had the PPP pack containing information to give to people. The pharmacy monitored people on high risk medication and recorded the information received on the electronic patient medication record (PMR). 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 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 a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacist handed out prescriptions to people to advise them of the dose to take and answer any questions.

The pharmacy team checked the expiry dates on stock. The team had a list of medicines with short expiry dates. And used coloured dots to highlight medicines with a short expiry date. But this list was only up to June 2019. So, medicines with expiry dates after this were not marked. This meant that the team would not have a prompt to check the medicine and ensure it was appropriate to supply. 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. 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 no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 09 February 2019. And the team hadn't received any training. 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.

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 a fridge to store medicines kept at these temperatures. The fridge had a glass door to enable stock to be viewed without prolong opening of the door. The pharmacy completed safety checks on the electronic equipment.

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. And they used cordless telephones to make sure telephone conversations were held in private.

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.