General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M Manning (Pharmacy) Ltd., 97 Lidgett Lane, LEEDS, West Yorkshire, LS8 1QR

Pharmacy reference: 1039759

Type of pharmacy: Community

Date of inspection: 24/01/2024

Pharmacy context

This community pharmacy is in a large suburb of Leeds. Its 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 correctly. And it delivers medicines to some people's homes. The pharmacy provides other NHS services including the hypertension case finding service. And the NHS New Medicines Service (NMS). The pharmacy provides the seasonal flu vaccination service and the COVID vaccination service. It also has a private travel clinic, where it provides travel advice and the administration of vaccines. And it dispenses private prescriptions for specific unlicensed controlled drugs.

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 generally identifies and manages the risks associated with most of its services. It completes the records it needs to by law and it protects people's private information properly. Pharmacy team members respond correctly when errors occur. And they take appropriate action to prevent future mistakes. The pharmacy provides team members with a range of up-to-date written procedures for them to follow. But some pharmacy services have limited information for the team to refer to when delivering the service.

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 team had read and signed the older version of the SOPs dated 2018 but had not read the reviewed SOPs that had been sent in an email. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy did not have a specific SOP for the dispensing and supply of specific unlicensed controlled drugs (CDs). A dispensing guide published by the manufacturer was available for team members to refer to. When planning this service and the travel clinic one of the regular pharmacists had completed informal risk assessments. These identified if the services would be beneficial to the local community. And to ensure that the delivery of both services would not impact on the team members' workload and the other services provided. These assessments had not been recorded to enable them to be referred to and reviewed when required. But they did not consider some of the specific risks about supplying unlicensed CDs, including the risk of oversupply, and dispensing medicines that look and sound similar. And the pharmacy had not carried out any audits on prescriptions to ensure supplies remained appropriate.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. The records were completed by the pharmacist or the accuracy checking pharmacy technician (ACPT) after discussing the error with the team member. A sample of completed near miss records showed details of what caused the error and the actions taken to prevent a similar error from happening again. For example, misreading the prescription and medicines that looked and sounded alike. One of the pharmacy technicians reviewed the near miss record to identify patterns to share with the team. And discussed with the team how to prevent errors from happening. But they didn't always keep a record of the review. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening. Team members highlighted to each other medicines that may contribute to an error. For example, when putting away stock and noticing medication with similar packaging. People using the pharmacy services were able to raise concerns with the team who took appropriate to address the concerns. Team members monitored feedback given by people using online platforms and responded to concerns raised.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and CD registers met legal requirements. The pharmacists

regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. And a random balance check undertaken during the inspection was correct. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. Appropriate records were kept of the receipt and supply of unlicensed medicines.

Team members completed training about protecting people's private information and the pharmacy had a dedicated information governance folder for the team to refer to. The team separated confidential waste for shredding onsite. The pharmacy had safeguarding guidance for the team to follow. And team members had completed training relevant to their roles. The delivery driver reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a good range of experience and skills to help safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. Team members have some opportunities to receive feedback and they are encouraged to complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

Regular part-time locum pharmacists covered the pharmacy's opening hours. The pharmacy team consisted of a part-time ACPT, a full-time trainee ACPT, a full-time pharmacy technician, three part-time dispensers, one part-time trainee dispenser, one full-time trainee medicines counter assistant (MCA), and one part-time delivery driver. At the time of the inspection most team members were on duty. The trainee ACPT had some managerial responsibilities to support the team in the absence of a pharmacist manager.

Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They shared key roles such as checking the expiry dates of the medicinal stock. Two of the pharmacy technicians had developed a team rota to ensure key tasks were completed especially at times of planned and unplanned absence. The pharmacy did not regularly hold team meetings, but important information was shared with all team members in small groups or one-to-one. And the team received emails from the company when information had to be shared.

The trainee ACPT had protected time at working to complete their modules and was supported to reach the number of items checked to meet the requirements of the training course. The trainee MCA also had protected time at work. In preparation for the launch of the NHS Pharmacy First service the team had received training from Community Pharmacy West Yorkshire. And the pharmacists had completed additional training reflecting their specific roles such as diagnosing the conditions listed within the service. All team members had received training from the company that issued prescriptions for specific unlicensed controlled drugs. This included information about the end-to-end product growth, transport and production. And guidance on the steps to take when dispensing this medication.

Team members had not received formal feedback on their performance for two years but regularly received informal feedback. And they had opportunities to develop their knowledge and skills. One of the dispensers had been trained as a vaccinator to support the pharmacists with services such as seasonal flu vaccination service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and generally provide a suitable environment for the services provided. It has appropriate facilities to meet the needs of people requiring privacy when using its services. But the room used for confidential conversations is not fully private.

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. They used a large upstairs room for dispensing and checking multi-compartment compliance packs. This room provided plenty of space for the team to work and was away from the distractions of the busy retail area. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where medicines for sale were healthcare related.

The pharmacy had a soundproof consultation room which the team used for private conversations with people and when providing services. However, the door into the consultation room from the public area had a small window which meant people in the retail area could see into the room. 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 help make sure people receive an efficient service and get their medicines when they need them. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door. Team members provided people with information on how to access other healthcare services. They asked appropriate questions when people requested over-the-counter medicines to ensure the most appropriate product was supplied. And they knew when to refer requests to the pharmacist. The computer on the pharmacy counter had access to the pharmacy's electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at.

The pharmacy technicians were trained to support the pharmacists with the NHS hypertension case finding service by taking people's blood pressure readings. The service was popular and several people had been identified as having undiagnosed hypertension and were referred to their GP for further tests and medication. The pharmacy technicians also supported the pharmacists with the NMS by asking relevant questions of the person. So, the pharmacists had all the information they required when assessing the person's new medication. The pharmacists providing the seasonal flu vaccination service and the COVID vaccination service worked within the framework of patient group directions (PGDs). The COVID vaccination service had been very popular as the service was not widely available in the area. The travel clinic was provided by one of the part-time pharmacists who worked with up-to-date PGDs. Team members were familiar with the service so they could provide people with details of the service and when to access it.

The pharmacy received a small number of prescriptions for specific unlicensed CDs issued by prescribers at a specialist clinic. The pharmacists spoke to people presenting at the pharmacy enquiring about the service before the person was signposted to the specialist clinic. The pharmacists established what medical condition the person was seeking treatment for. And confirmed they'd had a diagnosis of the medical condition from their GP who had prescribed other medication that the person had tried. This enabled the person to know that the criteria set by the clinic for a referral was met before they presented at the clinic. And it helped to ensure any medication prescribed was suitable for the person. The pharmacy team ordered the medication from the specialist manufacturer on receipt of the prescription and payment from the person. Deliveries were made to the pharmacy via a courier used by the manufacturer in unmarked boxes. The pharmacy contacted the person when the medication was ready to collect. And sent reminders to ensure the person received the medication within the 28-day legal limit.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. Most prescriptions were sent to the pharmacy as electronic repeat dispensing and were available to download each week. To manage the volume of packs the team dispensed and checked four weeks of packs together against the first repeat prescription and the person's medication list kept at the pharmacy. The medication list captured the person's current medication and dose times which team members referred to during the dispensing and checking of the packs. The team supplied the

remaining packs each week after downloading the next weekly prescription and completing another accuracy check of the dispensed medicines in the pack. Team members kept a record showing when each person's pack had been completed and supplied for them to refer to when queries arose. They recorded the descriptions of the products within the packs but did not always supply the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs but did not always have all the information about their medicines. Team members updated the person's medication list after being advised of changes to their medication. They kept the email communication from the person's GP advising of the change and copies of hospital discharge summaries sent via the NHS communication platform.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were partially prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The dispensing label was generated and attached to an empty bottle. When the person presented the dose was measured and checked before adding to the labelled bottle and supplying to the person. 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) including the requirement to supply original packs of valproate. And reported that 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. And they used a separate system to capture the pharmacist's clinical check which enabled the ACPT to complete their check. The pharmacy used clear bags to hold dispensed CDs and fridge lines to enable the team, and the person collecting the medication, to check the supply. And it had CD and fridge stickers for team members to attach to bags and prescriptions to remind them when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, the team provided the person with a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people for team members to refer to when queries about deliveries arose.

The pharmacy obtained medication from several reputable sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. They checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were clearly 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. The team checked and recorded fridge temperatures each day and a sample of these records showed the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And 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. Team members responded appropriately to these alerts and kept a record of their actions. Alerts that were related to medicines usually stored in the pharmacy were printed off and attached to the storage area where the stock was held. So, all team members were aware.

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. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. And two fridges to hold medicines requiring storage at these temperatures.

The pharmacy computers were password protected and access to people's records 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 and rear areas 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.