General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Adel Pharmacy, 141 Long Causeway, LEEDS, West Yorkshire, LS16 8BX

Pharmacy reference: 1039761

Type of pharmacy: Community

Date of inspection: 16/04/2019

Pharmacy context

The pharmacy is next door to a small GP surgery in a suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. It provides multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy provides flu vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. But they have not been recently reviewed or signed by all the team. This means there is a risk that team members may not understand or follow correct procedures. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't record all errors or review them. This means that the team does not have information to identify patterns and reduce mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

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. Some SOPs had review dates due May 2015 and May 2016. Other review dates were set as 2017. But there was no evidence this had happened. The delivery driver had not read and signed the SOPs to show they understood and would follow them. The pharmacy had up to date Indemnity insurance.

The pharmacy provided separate areas for the labelling, dispensing and checking of prescriptions. The team used baskets throughout the dispensing process to hold stock, prescriptions and dispensing labels. On most occasions the pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. Rather than getting them to identify their own error. The pharmacist discussed errors with the team. And recorded them when considered serious. This meant that the team missed opportunities to spot patterns with all errors. And to take appropriate action to prevent similar mistakes from reoccurring. The near miss log showed one entry since 2018. The pharmacy had forms to record dispensing errors. The pharmacy didn't have completed forms available to show this had happened. The pharmacist recorded the error on to the person's electronic record.

The team discussed errors and how to prevent them. The team discussed always doing a full check of the drug name, strength and quantity when dispensing. The team attached notices to drawers prompting them to check the item picked. For example, amitriptyline and amlodipine. The team recently introduced a system to record the quantity in a box on the inside flap. This was in place following concerns from a person that they hadn't received the correct amount of medication.

The pharmacy had a poster with information on how to make a complaint. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy did not always reconcile the amount of CD stock with the value in the register. The pharmacy removed out of date CD stock from the balance in the CD register. This meant that information in the CD register was not accurate. A sample of Responsible Pharmacist records looked at found they mostly met legal requirements. But the time the pharmacist signed out as Responsible Pharmacist was not recorded. The Responsible Pharmacist notice was not on display. The frame holding the notice had broken. So, the pharmacist used adhesive to attach it to the wall. Details of private prescription supplies met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they were being kept under the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy had confidentiality and data protection policies. And it provided people with information on how it complied with the Data Protection Act and NHS Code of Confidentiality. The team received training on the General Data Protection Regulation (GDPR). The pharmacy held completed prescriptions away from public view. And it kept other patient sensitive information in the dispensary which had restricted access. The team placed confidential waste into a separate marked bin. And removed it for offsite shredding.

The pharmacy had information on posters about safeguarding procedures. The pharmacist had not completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2018. And attended a training session given by Community Pharmacy West Yorkshire. The delivery driver reported any concerns to the team about people they delivered medication to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the qualifications and skills to support the pharmacy's services. The team members discuss how they can make improvements. And they act to support the safe and efficient delivery of these services. The pharmacy team members get feedback on their performance. And they have some opportunities to complete more training. So, they can keep their skills and knowledge up-to-date.

Inspector's evidence

The pharmacist manager with locum pharmacist support covered the opening hours. The pharmacy team consisted of two qualified dispensers and a delivery driver who was doing the medicine counter assistant training. The delivery driver helped the team in times of absence. And was supporting the team when one of the dispensers was off sick. This dispenser managed the supply of multi-compartmental compliance packs. In the absence of the dispenser the pharmacist manager managed the service. But it had highlighted the importance of training the other dispenser. Which was taking place.

The pharmacy provided extra training through monthly reading materials. And the pharmacist shared learning from events she attended. The team also shared information and learning via a WhatsApp group. The team members received annual performance reviews. These gave them a chance to receive feedback and discuss development needs. One of the dispensers had taken the opportunity to ask about the level 3 national vocational qualification.

The pharmacist was set targets for services such as medicine use reviews (MURs). The pharmacist performed these services when appropriate for the patient's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic with 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 room was also used as an office and store room. And it was cluttered and untidy. The team used cordless telephones for confidential conversations. The premises were secure. The pharmacy had restricted access to the dispensary when the pharmacy was open. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. But the team do not always supply information leaflets with medication to help people take their medicines safely. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a ramp with a hand rail. The pharmacy door had a bell to alert the team to people who may need help. The pharmacy didn't have an information leaflet about services or contact details, for people to pick up. The team could access the internet when signposting patients requiring a particular service. A small range of healthcare information leaflets were available. The pharmacy displayed a poster detailing the amount of sugar in a range of drinks. This triggered conversations with people who expressed surprise at the amount of sugar. And discussed alternatives with the team. The pharmacist worked with a hospital pharmacist to organise an inhaler technique workshop at local sheltered housing. This resulted in people attending the pharmacy for checks. The pharmacist was planning other events such as diabetes awareness and dieting. The pharmacist asked people living in the sheltered housing what subjects they wished to know more about.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. One of the dispensers managed the service. The pharmacist spent time with new patients explaining how the pack worked. The team usually ordered 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. Some prescriptions came as repeat dispensing. Each patient had a record listing their current medication and dose times. The team checked received prescriptions against the list. This helped identify missing items or changes. The team used disposable gloves when dispensing medication in to the packs. The team usually wrote descriptions of the products within the packs. The pharmacy didn't always supply the manufacturer's patient information leaflets. Copies of hospital discharge summaries were usually sent via PharmOutcomes. The pharmacist checked the discharge summary for changes or new items. The pharmacist asked for prescriptions to send new packs when changes occurred.

The team provided a repeat prescription ordering service. And placed requests two days before supply. This gave some time to deal with issues such as missing items. The pharmacy kept a record to help identify missing prescriptions. The team passed information from the GP team on to the person such as the need to attend the surgery for medication reviews or blood tests. Some GP teams no longer excepted repeat prescription requests from the pharmacy. The team worked with these GP teams to identify people who would struggle to order their prescriptions. And for these people the pharmacy took back this role. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no people within the category. The pharmacy had received the PPP pack containing information cards and leaflets to pass on to patients. But the team could not locate it. Patient information cards held with valproate stock had expired in January 2016. The team asked people prescribed high risk medication such as warfarin if they'd had blood tests or knew their doses. The team didn't record this on the person's electronic medication

record. So, the team didn't have access to up to date information.

The pharmacy used controlled drug (CD) and fridge stickers on bags and prescriptions to remind the team member handing the medication over to add these items. The pharmacy had checked by/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 mostly completed both boxes. When the pharmacy didn’t have enough stock of someone’s medicine, they provided a printed slip detailing the item owed. And it kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The driver scanned the bar code on the bag label on taking the medication from the pharmacy.

The pharmacy team checked the expiry dates on stock every week. But it didn’t keep a date record showing this had happened. The team marked the packaging to highlight short dated stock. No out of date stock was found. The team recorded fridge temperatures daily. And a sample looked at found them to be within the accepted range. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. But an opened bottle of Oramorph with 3 months use once opened didn't have an opening date recorded. The pharmacy had appropriate medicinal waste bins for out of date stock and patient returned medication. The team separated out of date CDs from in date stock in a CD cabinet that met with legal requirements. The team recorded patient returned CDs and used denaturing kits for CD destruction.

The pharmacy head office was arranging for a computer update and installing of 2D scanners to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 09 February 2019. 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 the internal notification system. The team actioned the alert and recorded when this happened.

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 quality marked measuring cylinders to accurately measure liquid medication. The pharmacy had a pharmacy fridge to store medicines kept at these temperatures.

The computers were password protected and access to patients' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information.

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.