General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 139 Shadwell Lane, LEEDS, West Yorkshire, LS17 8AE

Pharmacy reference: 1039820

Type of pharmacy: Community

Date of inspection: 13/03/2024

Pharmacy context

The pharmacy is in the suburbs of Leeds, next to a medical centre. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It delivers some medicines to people in their homes. And it provides a range of services, including the NHS Pharmacy First service and blood pressure monitoring service.

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 has up-to-date written procedures to help team members complete tasks in a consistent and safe way. And it correctly completes the records that need to be kept by law. Team members keep people's confidential information safe and they have some knowledge of what to do to help protect vulnerable people's welfare. They regularly record, review, and learn from mistakes they make. And they make changes to the way they work to reduce the risk of similar mistakes happening again. The pharmacy has appropriate insurance to protect people if something goes wrong.

Inspector's evidence

The pharmacy had electronic standard operating procedures (SOPs), this included for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. The sample of SOPs seen had been reviewed in 2022 and 2023. Each team member had an electronic record of training they had completed, which the pharmacist manager could view to ensure they were up to date. They also received reminders from the area manager if SOP modules were not completed when they were due. The pharmacist manager had read the SOPs and they confirmed team members were up to date with this training.

Pharmacy team members recorded near miss errors electronically and from the records seen this was done regularly throughout the month. These errors were ones that were identified before people received their medicines. The team member who had made the error entered the details on the system so they could reflect on what happened. They recorded what the error was and the details of the medicines involved, but they rarely entered the reason for the error or actions taken. The pharmacist manager completed a documented analysis of these errors monthly and shared the findings with the team in informal meetings. They had identified some quantity errors were common due to different pack sizes and how these were separated on the shelves to help reduce the risk of the error happening again. The pharmacy received a professional newsletter, which identified errors that had happened in other pharmacies in the company and allowed the team to learn from these. The pharmacy recorded and reported dispensing errors online to the pharmacy superintendent's team. These were errors that were identified after the person had received their medicine. They kept printed records in the pharmacy in case of queries and enough detail to show what the learnings had been, and actions taken.

The correct RP notice was displayed, and was visible at the pharmacy counter. Team members were aware of their roles and responsibilities and were observed working within the scope of their roles. A dispenser correctly described what could and couldn't be done in the absence of the RP. The pharmacy had a complaints SOP, including an escalation process to the pharmacy superintendent's team. The pharmacist manager was confident in responding to concerns. The poster in the retail area encouraged people to give feedback, and detailed how this could be done.

The pharmacy had current professional indemnity insurance. It had electronic private prescription records, that appeared to be completed correctly. There were records of emergency supplies containing the required details, including a reason for the supply. The pharmacy held up-to-date electronic CD registers, with checks of the physical stock against the register balance recorded weekly. The two checks of the physical quantity completed against the register balance during the inspection were correct. The pharmacy kept an electronic record for CDs returned by people for destruction as no

longer needed and entries were made on receipt of the CD and on its destruction so there was an accurate audit trail.

Team members understood what to do to keep people's personal information safe and they separated confidential waste from general waste using a large bin from a specialist third-party contractor. The waste was collected and shredded by them monthly. There was a privacy policy displayed in the retail area for people to read. The company had a data protection (DP) policy, and it provided annual DP training for team members. The pharmacist's completed DP training record was seen for 2023/24. The pharmacist had completed level 3 safeguarding training in 2023. A team member explained how if they were concerned about a vulnerable person, they would discuss this with the pharmacist. The pharmacy had a chaperone policy, which was advertised on the consultation room door.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy supports its team to make sure it has enough team members to manage the workload. Team members complete regular ongoing training to keep their skills and knowledge up to date. And they feel comfortable in raising any concerns and providing feedback.

Inspector's evidence

The RP was the pharmacist manager and they had worked there for several years. During the inspection they were supported by two trainee relief dispensers, who usually worked at different pharmacies in the same company. One member of the team was on annual leave and the other dispenser arrived to start their shift just as the inspection finished. Team members were seen managing the workload and referring to the pharmacist when they were unsure of a process and to give advice. One of the trainees had started with the company in November 2023 and had no prior experience in a pharmacy setting. They were seen to be supervised by the pharmacist and the other dispenser whilst they worked. The trainee described how they referred all over-the-counter requests to the pharmacist. A delivery driver worked five days a week and there was a maximum number of deliveries allocated each day to ensure their workload was manageable. The pharmacist confirmed that people were understanding of this process and that there was another pharmacy locally that provided a delivery service and sometimes people used that pharmacy if they needed to. The pharmacist confirmed that relief staffing cover was available when needed and they felt supported by the area manager to ensure there were enough staff available to manage the workload.

Team members had access to a variety of online training modules, some of which were mandatory. They completed training during the working day when time allowed. Some team members preferred to complete training at home as they were free from distractions. The pharmacist had completed the required training for the NHSE Pharmacy First service and had provided the service on several occasions since the service began a few weeks previously. A dispenser knew the risks of people taking codeine-containing painkillers and explained the advice she gave people and how she referred to the pharmacist if people had been purchasing painkillers regularly. The pharmacy team held informal meetings to share information and learn from mistakes.

The pharmacist was comfortable raising concerns to the area manager, who took any feedback seriously and put plans in place to resolve any issues. The pharmacy set a variety of targets for the team to meet and there was a poster in the dispensary showing the team how the pharmacy was performing. The pharmacist had no concerns over meeting the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriately clean and hygienic. And they provide a suitable environment for healthcare services. People use a spacious and well-lit consultation room to access services and speak with team members in private.

Inspector's evidence

The pharmacy had a large retail area, which was clean and portrayed a professional image. The pharmacy counter provided a barrier to prevent unauthorised access to staff only areas of the pharmacy. And the dispensary floor was at a raised level to the retail area, which supported the pharmacist to supervise sales of medicines from their prescription checking area. The layout of the dispensary and the amount of bench space allowed for an organised workflow. The lighting and temperature were suitable to work in and to provide healthcare services. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic and there were posters demonstrating to team members how to wash their hands properly.

The pharmacy had a private consultation room, which was spacious, light and had a professional appearance. There were two entrances one for the person accessing services and one for team members. Access into the room was controlled and the door was kept locked.

Principle 4 - Services ✔ Standards met

Summary findings

People access the pharmacy's services easily. Team members manage its services effectively. And they use technology well to improve the safety and efficiency of its services. The pharmacy obtains its medicines from recognised suppliers. And it stores and manages its medicines as it should. It makes appropriate checks to ensure its medicines are suitable to supply to people.

Inspector's evidence

There was a car park for the pharmacy and other businesses. The pharmacy had level access and wide doors for people to enter, including those using wheelchairs and with prams. It had a large retail area with wide aisles, seats, and a working hearing loop for people using hearing aids. The team advertised a health promotion zone in the retail area and displayed posters and leaflets about healthcare topics and services. It had recently started providing the NHSE Pharmacy First service and had signed patient group directions (PGDs) for different pathways. The pharmacy provided a medicines delivery service two days a week. The deliveries were stored separately, and the driver scanned barcodes on each bag of medicines to enter them on to the online delivery application. This then organised their route and provided an audit trail for the deliveries made. There were also paper delivery sheets produced, which could be folded to prevent people's names and addresses being shared. Some people collected their multi-compartment compliance packs from the pharmacy, that had been dispensed by another pharmacy in the company. The delivery driver transferred them from the other pharmacy and used their delivery application to scan the packs, so there was an audit trail of the deliveries. There was good communication between pharmacies, such as when people didn't collect the packs or if the pharmacy was informed of a person being admitted to hospital. But this procedure wasn't written down for team members to refer to in case of queries.

The pharmacy had an organised workflow, with enough bench space for dispensing and checking. A high percentage of the prescriptions were assembled at an offsite hub pharmacy, using automation. The pharmacist completed a clinical check of these prescriptions on the patient medication record (PMR) system. And there was an accuracy check of the data inputted before it was submitted to the hub pharmacy for assembly. The pharmacy annotated prescriptions that were dispensed at the hub and filed them awaiting delivery of the assembled medicines from the hub. There were safeguards in the system to allow for urgent prescriptions to be cancelled for dispensing at the hub pharmacy and dispensed locally. Scanning of barcodes meant that people didn't receive duplicate supplies from the prescription when this happened. The pharmacist completed an accuracy check each day on two prescriptions received back from the hub pharmacy, as part of a quality assurance process. The pharmacy used dispensing aids to manage risk in the dispensing process. This included using baskets to keep people's prescriptions and medicines together to reduce the risk of errors. And the use of stickers to highlight when people may benefit from services such as a blood pressure check or from pharmacist advice. Team members initialled dispensed by and checked by boxes on the dispensing labels to provide an audit trail. The pharmacist showed a good understanding of the requirements of dispensing valproate for people who may become pregnant and of the recent safety alert updates. The team dispensed prescriptions in original manufacturer's packs. And it had patient cards, stickers and a poster displayed in dispensary to refer to. The team had completed audits for some higher-risk medicines such as warfarin and made intervention records on people's PMR. The pharmacist acknowledged written interventions were not always recorded on each dispensing. But they understood the benefits of doing

this for people's care.

Pharmacy-only (P) medicines were displayed behind the pharmacy counter, to help make sure sales were supervised by the pharmacist. Medicines on the dispensary shelves were kept in a tidy and orderly manner. The team regularly checked the expiry dates of stock according to a schedule, and kept electronic date checking records showing the checks were up to date. There were no out-of-date medicines found from a sample checked. The pharmacy used dedicated bins for pharmaceutical waste, and these were collected by a third-party contractor monthly. The pharmacy stored medicines requiring cold storage in a medical fridge, and the team kept daily records which showed the temperatures were within the required range. The pharmacy stored its CDs securely. The team printed medicine recalls and safety alerts and kept records of actions they had taken. These records were up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to suitable equipment for the services they provide. And it is fit for purpose and safe to use. Team members use the equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had reference resources available including the British National Formulary (BNF). Team members had access to the internet and intranet to support them in obtaining current information to help them in their role. A range of equipment was available for use in the consultation room. The pharmacist confirmed new equipment, such as a blood pressure monitor, and otoscope had been recently purchased to provide the NHS Pharmacy First Service. Other equipment, such as the weighing scales were due for calibration in November 2024. There was an open sharps bin in the consultation room, underneath where people sat for consultations and the positioning of this was discussed with the pharmacist. Electrical equipment was visibly free from wear and tear and appeared in good working order. The pharmacy had different sized CE marked measuring cylinders for liquids, that were clean and appropriate for use.

Prescriptions awaiting collection were stored on shelves in a retrieval area and confidential information was not visible to people waiting in the retail area. Computers were password protected and team members were seen using individual NHS smart cards to access computers. Computer screens were protected from unauthorised view and a cordless telephone was available for private conversations in a quieter area.

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.