General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Beeston Distric Centre, Town Street, LEEDS, West Yorkshire, LS11 8PN

Pharmacy reference: 1039831

Type of pharmacy: Community

Date of inspection: 13/02/2024

Pharmacy context

This pharmacy is amongst a parade of shops in a large suburb of Leeds. It dispenses NHS prescriptions. And it supplies several people with their medicines in multi-compartment compliance packs to help them take their medication properly. The pharmacy provides other services including the NHS Pharmacy First service and the NHS hypertension case finding service.

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 well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps 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 by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. Team members accessed the SOPs through personal log-in numbers. And completed a quiz connected to each SOP to show they had read, understood and would follow the SOP. The pharmacist manager had access to all team members accounts so could monitor their progress in completing them. And was advised of new SOPs and amendments to existing ones. A set of SOPs had been sent to the team to support the delivery of the NHS Pharmacy First service. Team members 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 and correct it. A record of the error was made on an electronic platform by the team member involved or the pharmacist after speaking to the team member. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. A dispensing incident report was completed along with a root cause analysis to identify the reason the error occurred. So, action could be taken to prevent similar errors from happening again. All team members were informed of the error, and they discussed how to prevent such errors from happening. Following a dispensing incident when the wrong strength of medication had been supplied the team identified the factors contributing to the error were both strengths being stored next to each other. And the pharmacist had been interrupted when completing the final check of the dispensed prescription. To prevent this error from happening again the team had separated the two strengths of the medication. And attached a note to the shelf to prompt them to check the strength they had selected. However, at the time of the inspection the two strengths were found next to each other. This was highlighted to team members who separated the two strengths. Since the dispensing incident the pharmacist tried to avoid being interrupted when completing the final check of prescriptions. When this was unavoidable, they would re-start the checking process. The pharmacist manager regularly reviewed the near miss errors and dispensing incidents. And shared the outcome from the review with team members, who discussed the changes they could make to prevent errors. A recent review was used to remind team members to ensure the dose directions on the label were clear for people to read and understand. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And a poster in the retail area along with information on the company's website provided people with details on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records, private prescriptions 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. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. And had been signed by the pharmacist to show they had read them, understood them and would follow them.

Team members knew how to manage people's confidential information and the pharmacy displayed a privacy notice. Confidential waste was separated and shredded offsite. The pharmacy had safeguarding procedures and provided 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. Team members work well together, and they are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the effective delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy technician, two full-time dispensers, one part-time dispenser and a part-time medicines counter assistant. At the time of the inspection all team members except the pharmacy technician were present. Team members worked well together and experienced team members were encouraged to use their knowledge and skills to support the team. Some team members had specific tasks, however all team members knew how to undertake key tasks and a daily rota allocated tasks amongst the team. This ensured these tasks were completed regularly especially at times when team numbers were reduced such as planned and unplanned absence.

Team members used company online training modules to keep their knowledge up to date and they had some protected time at work to complete the training. All team members had completed online training in preparation for the NHS Pharmacy First service and had read the accompanying SOPs. The pharmacist had previously completed face-to-face training on using an otoscope for examining people's ears. This training was provided to support a local NHS service for diagnosing and treating simple ear infections that was in place before the Pharmacy First service was introduced. Most team members were trained on using the blood pressure monitor so they could help the pharmacist with the NHS hypertension case finding service.

Team members received formal performance reviews so they could identify opportunities to develop their knowledge and skills. The pharmacist manager had discussed with one of the dispensers that they had the skills and experience to enrol on to a pharmacy technician course. And provided information about the training for the dispenser to consider. The pharmacy regularly held team meetings and team members could suggest changes to processes or new ideas of working. One of the dispensers had introduced a system of highlighting the person's name on the prescription for people with similar names. And had established a process for team members to attach stickers to prescriptions containing antibiotics so they could be clearly identified and dispensed promptly.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and provide a suitable environment 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 large and the team kept them tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing with hot and cold water available. 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. The pharmacy had plenty of 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. There was a soundproof consultation room which the team used for private conversations with people and when providing services. 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 for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. Team members asked appropriate questions when selling over-the-counter products and knew when to refer to the pharmacist. Some team members spoke Punjab and Urdu and the team accessed an online platform to translate other languages. This helped to ensure people received the correct information about their medication. The team used the pharmacy's electronic patient medication record (PMR) to record key pieces of information such as a person's allergy to certain medicines or the ingredients used in a medicine.

The hypertension case finding service was popular and had resulted in some people being referred for further tests. Team members attached stickers to prescriptions to prompt them to discuss the service with people when they collected their medication and invite them to have their blood pressure checked. The NHS Pharmacy First service was popular and several people had presented since its launch with sore throats and sinusitis being the most common symptoms.

The pharmacy sent several prescriptions to the Well offsite hub pharmacy to be assembled there. Before sending the prescription information, the team processed the prescriptions, and the pharmacist completed a clinical check. Some medicines such as CDs and items the person urgently needed were dispensed at the pharmacy to reduce risk. And to ensure people's medicines were ready when they needed them. Most dispensed prescriptions from the hub were returned to the pharmacy the following day. They were supplied in a sealed bag with an embedded bar code, which the team scanned to confirm receipt. Team members matched any prescriptions dispensed at the pharmacy with prescriptions for the same person sent from the hub. And they used the bar code scanning technology to locate where all the completed prescriptions for a person were held to ensure people received all their medicines.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. The pharmacy technician managed this service with support from other team members. To manage the workload the team divided the preparation of the packs across the month. And prescriptions were generally issued as electronic repeat dispensing prescriptions. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of prescriptions. The records also included a section to record changes and the outcome from queries. The team generally recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This helped people identify the medicines in the packs and they had information about their medicines. However, some descriptions were limited to the word tablets rather than the details of any distinguishable features to differentiate the medicine from other medication in the packs. The pharmacy received copies of hospital discharge summaries via the

NHS communication system which the team checked for changes and new items.

The team members provided a repeat prescription ordering service for some people to help them get their medication on time. They usually ordered the prescriptions a week before supply. And they kept records of the prescriptions requested to identify missing prescriptions so they could contact the GP team. The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria and they supplied valproate in original packs. One person prescribed valproate had met the PPP criteria and the pharmacist had spoken to the person. But a record of the conversation had not been made on the PMR so other pharmacists and team members were aware. After this was highlighted the pharmacist updated the PMR with details of the conversation. 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. And were stored securely with people's doses separated to reduce the risk of selecting the wrong one.

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. 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. The text message was only sent when all the prescriptions sent to the offsite pharmacy and dispensed at the pharmacy were complete. Team members regularly checked the section holding completed prescriptions and sent a second text message to remind people to collect their medication. The pharmacy 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 and team members followed procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were 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. They 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. CDs were stored securely and out-of-date CDs were separated and clearly marked. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were 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 the company communication platform. These were printed off and signed by the pharmacist to show they had taken appropriate action.

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. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. And a large fridge for holding medicines requiring storage at this temperature. The fridge had a glass door that enabled the team to view stock without prolonged opening of the door.

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