General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Seacroft Pharmacy, 868 York Road, LEEDS, West Yorkshire, LS14 6DX

Pharmacy reference: 1039851

Type of pharmacy: Community

Date of inspection: 03/09/2019

Pharmacy context

This community pharmacy is in a small parade of shops in a suburb of Leeds. The pharmacy dispenses NHS and private prescriptions to people in the local community, to students at a private boarding school and to people at Wetherby Young Offenders prison. The pharmacy provides medication in multi-compartmental compliance packs to help people take their medicines. And over-the-counter medicines via the Pharmacy First scheme.

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	2.5	Good practice	Team members with managerial responsibility identify improvements to the delivery of pharmacy services. The team actively share ideas. And the pharmacy makes improvements to the delivery of pharmacy services in response to suggestions by the team members.
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 suitable arrangements to identify and manage risks with its services. And it has adequate arrangements to protect people's private information. The pharmacy keeps the records it needs to by law. People using the pharmacy can raise concerns and provide feedback. And the pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They review and discuss what occurred. And they act to prevent future mistakes. The pharmacy has written procedures that the team follows. But not all the team members have signed to say they have read the procedures. This means there is a risk that some team members may not be following up-to-date procedures. And the possibility that they may not understand the procedures in place.

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 SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The SOPs had signature sheets for the team to show they understood and would follow them. Not all the team members had signed the sheets. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors. But the team had not recorded errors made in July 2019 and August 2019. The branch pharmacist was aware of this. And had already spoke to the team members about it. The pharmacist reminded the team of the importance of recording and learning from these mistakes. The pharmacist asked the team to record their own errors and show the entry to her. To support this the pharmacist kept blank record sheets on the dispensary wall. So, the team could easily find them. A sample of the error records from May 2019 and June 2019 found the team recorded details of what had been dispensed and used codes for the type of error. But the records did not capture the details from the prescription to help spot patterns. The records captured the actions taken to prevent the same mistake. But the entries had the same response which was correcting the error. The team captured the learning points from these errors, but they were usually to scan and double check the item picked. So, there was no evidence of individual learning. The pharmacy team reported dispensing incidents electronically and printed them off. The pharmacy only sent a copy of the report to head office when the team rated it as important. This meant the head office team would not have a full picture of errors to spot patterns. And would find it difficult to identify areas for improvements to share with all teams. The team attached labels to the shelves holding products often involved with picking errors. The labels highlighted the name of the product to act as a prompt to the team when selecting an item. For example, propranolol was written as proPRANolol.

The pharmacy had a template to capture monthly patient safety reviews. And it completed an annual patient safety review. The last monthly review was March 2019. This referred to the team scanning all dispensed items. And rectifying mistakes before handing the dispensed medicines to the pharmacist to check. The pharmacy had a bar code scanning system. This involved the team scanning the product selected. And then scanning the bar code on the attached dispensing label to see if they matched. An

alert prompted the team member when they had selected the wrong product. The team members ticked the label to show there was a match. And used a cross to show they had double checked the product selected after receiving an alert at the scanning stage. The pharmacist sent back any dispensed items that had no markings on them to remind the team to always indicate that they had scanned the item. The pharmacist asked the team members why they didn't always use the scanner. And they explained this was often due to the computer not being available at the point in the dispensing process when they would be scanning. So, the pharmacist asked the team members to request colleagues to move away from the computer to allow access when they were at the scanning stage. Or to gather a few baskets together in a tote box to take to the upstairs room to use the computer. The pharmacist informed the team that scanning and checking at the early stages of dispensing helped efficiency. And explained to the team the time taken to correct mistakes found at the pharmacist's final check disrupted the workflow. And added to the time taken to complete a prescription. The pharmacist reported a reduction in picking errors when the team used this system.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the pharmacy window.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. Some of the CD registers were coming loose from the folder. This ran the risk of losing these records. 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, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with GDPR requirements. And it had a leaflet explaining what confidential was kept by the pharmacy and how it safeguarded this information. The team separated confidential waste for shredding offsite.

The pharmacy provided information to the team on how to raise a safeguarding concern. And team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team had not had the occasion to report any safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And the team members support each other in their day-to-day work. Team members with managerial responsibility identify improvements to the delivery of pharmacy services. And introduce systems to improve team members efficiency and skills. The pharmacy supports an open and honest culture with the team members. They openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacy team members look for ways to improve how they work. And to ensure they use the tools within the pharmacy to help provide safe services. The pharmacy provides feedback to team members on their performance. So, they can identify areas to develop their skills. But the training it provides for team members is limited. So, they may miss the opportunity to keep their knowledge up to date.

Inspector's evidence

The branch pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a pharmacy pre-registration student, one full-time dispenser, one part-time dispenser and a full-time pharmacy apprentice. The pharmacy apprentice training covered medicine counter assistant training and dispenser training. The delivery drivers worked across the different pharmacies in the company. At the time of the inspection the branch pharmacist, the pre-registration student, the full-time dispenser, a relief dispenser and the pharmacy apprentice were on duty. The team supported the pre-registration student by giving them regular opportunities to speak to people and answer any queries. The pharmacy did not regularly provide extra training for the team. The training that was provided included pharmacy knowledge from emails sent to the pharmacy or first aid courses.

The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist designed a template to capture the team members personal development plans. Recent performance reviews included objectives for the team to focus on customer service. The pharmacy held huddles when team members discussed a range of matters including dispensing errors. And team members could suggest changes to processes and new ideas of working. The team members asked the pharmacist for a rota of key tasks that they could refer to. And to help ensure they completed these tasks. The pharmacist had developed a rota including tasks such as checking NHS emails. The rota named the team member responsible for completing the task. And it had a section to tick when the team member had completed the task. The full-time dispenser had suggested changing the numbering of the shelves holding completed prescriptions awaiting collection. The team changed the numbers so the shelves were less tightly packed. And made it easier to locate the prescription.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was little pressure to achieve them. The pharmacist offered the services when they would benefit people. The team helped deliver services such as MURs by identifying people that may want the service. And when the person agreed to the service the team prepared the paperwork for the person to complete. Before they spoke to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And the team used alcohol gel for hand cleansing. The pharmacy displayed notices advising the team on correct hand washing techniques. 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 large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. And 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 manages its services appropriately. It gets its medicines from reputable sources and it stores and manages its medicines well. The pharmacy team takes care when dispensing medicines into multi-compartmental compliance packs to help people take their medication. And it keeps records about prescription requests up to date. So, this enables the team to deal with any queries effectively. The pharmacy delivers medicines to people's homes. But it doesn't always obtain signatures from people for the receipt of their medicines. So, the pharmacy doesn't have a robust audit trail. And cannot evidence the safe delivery of people's medicines which could mean queries may be difficult to resolve.

Inspector's evidence

The pharmacy front door had a buzzer triggered by people entering the pharmacy. This alerted the team to their presence. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team had access to the internet to direct people to other healthcare services. The pharmacy displayed the opening hours in the windows.

The pharmacy provided multi-compartmental compliance packs to help around 10 people take their medicines. The team had provided the service to more people. But most people had moved their prescriptions to another pharmacy in the company that had capacity to do the service. The pharmacy obtained consent from people for this move. Some people who remained with this pharmacy had queries with their medication. So, the pharmacist wanted to resolve these issues before transferring these prescriptions. The team were moving people's prescriptions across to the other pharmacy in small groups to enable the team at the other branch to adjust to the increased workload. The team usually ordered prescriptions one week before supply. Or the prescription came via the repeat dispensing system. This allowed the team time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used an upstairs room to dispense the medication in to the packs. This was away from the distractions of the main dispensary and retail area. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. 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 pharmacy prepared the methadone doses in advance 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 with the prescription attached to the dose due. The pharmacist completed a second check of the prescription and prepared dose at the point of supply.

The team members provided a repeat prescription ordering service. People rang the pharmacy to order their medicines. And the team members used an electronic system to remind them when they had to request the prescription. The pharmacy used the electronic system as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team passed on information to

people from their GP such as the need to attend the surgery for a medication review. The team recorded this information on to the person's electronic record (PMR) so all the team were aware. And could pass it on to the person. The pharmacy received most prescription electronically (EPS). The team printed off the prescription and checked it against the order. Before placing the prescription in a basket labelled with the day of the week the supply was due. This helped the team locate the prescription when the person presented or if there was a query. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme (PPP). And they had access to PPP information to give to people.

The team received NHS prescriptions for the students at a boarding school. And kept a record when the pharmacy sent the medicines. The prescriptions for Wetherby Young Offenders prison were on specific templates used in the prison service. The team had to ensure they made supplies under the instructions of in-possession or not in-possession. These instructions related to the person having their medicine with them. Or a member of the prison healthcare team administering the medicine to the person. The pharmacy team provided appropriate containers to meet these instructions. For example, the team dispensed creams from metal tubes into plastic pots for medicines prescribed as in-possession. The pharmacy team agreed a cut-off time for supplies to the school and prison. This was because the delivery driver could only make deliveries once a day.

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 used clear bags to hold dispensed controlled drugs (CDs). This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. 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 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 pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. But only got signatures to prove receipt of CD medicines.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 20 August 2019. The team used coloured stickers with the date written on to highlight medicines with a short expiry date. 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 team also monitored and recorded room temperatures. The pharmacy had medicinal waste bins to store out-of-date stock and medication returned from people. And it stored out-of-date and patient returned 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 procedures, scanning equipment and had a computer upgrade to enable it to meet the requirements of the Falsified Medicines Directive (FMD). But the team members were not scanning FMD products as the pharmacy was waiting for a fix to be completed on the online system. The pharmacist highlighted to the team the issue that some opened FMD compliant packs did not have a facility to close. So, risked contents falling out. The pharmacist asked the team to use sticky labels to provide a temporary seal on the opened boxes. 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. This activity was included in the team rota.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it mostly protects 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 kept the cylinders for measuring methadone in a dedicated section labelled to show where to store them. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's 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 most private information in the dispensary and rear areas, which had restricted access. But paperwork containing people's names and address were on the table in the consultation room. The team 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.