

Registered pharmacy inspection report

Pharmacy Name: Well, 47 Scott Street, KEIGHLEY, West Yorkshire,
BD21 2JH

Pharmacy reference: 1084809

Type of pharmacy: Community

Date of inspection: 19/07/2019

Pharmacy context

The pharmacy is in a health centre in Keighley town centre. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. And offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption. And, they provide medicines in multi-compartmental compliance packs. The pharmacy sends some of its prescriptions to the Well dispensing hub for preparation off-site.

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	1.2	Good practice	The pharmacy has controls in place to continually review whether the technology being used continues to be effective. Pharmacy team members are good at discussing and recording mistakes they make. And, they proactively make changes when needed to the way they collect the data to help improve their learning.
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	4.2	Good practice	Pharmacy team members embrace new technology and ways of working. And they have the appropriate checks in place to review and monitor any changes in risks to the pharmacy's processes. This allows them to work in an effective way and manage pharmacy services safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy has some good procedures to manage the risks to its services. Pharmacy team members complete assessments to provide assurance they understand the procedures. And, they are clear about how to carry out their roles safely. The pharmacy effectively uses new technology to help reduce some of the risks associated with dispensing. And, it has controls in place to continually review whether the technology continues to be effective. The pharmacy keeps the records required by law. Pharmacy team members are good at discussing and recording mistakes they make. They proactively make changes when needed to the way they collect data to improve their learning. Pharmacy team members are good at responding to feedback. And, they use this feedback to improve the quality of their services. Pharmacy team members understand their responsibility to protect people's private information. And, they know what to do if they have a concern about the welfare of a child or vulnerable adult.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to manage the risks to its services. And, they were available for pharmacy team members electronically. The superintendent pharmacist's (SI) office reviewed the procedure every two years on a monthly rolling cycle. And, it sent new and updated procedures to pharmacy team members via the eExpert training system approximately each month. Pharmacy team members read the procedures. And, they completed a test after each one. If they passed the test, they could complete the sign off process as having read and understood it. The pharmacy defined the roles of the pharmacy team members in each SOP. And, tasks were further defined by frequent discussions amongst pharmacy team members.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes using an electronic reporting system called DATIX. The pharmacy team discussed the errors made. And, they discussed why they thought the errors had happened. The data collected was analysed by the pharmacist. And, pharmacy team members discussed the results of the analysis at a monthly huddle. They made changes to help prevent similar errors happening again, such as attaching alert stickers in front of products that had been involved in an error. And, by separating similarly named or packaged medicines. The pharmacist explained he had also noticed that not all errors were being recorded by the volume of data being collected. And, he had discussed this with the team. He said he had reinforced the no-blame culture of error reporting. And, pharmacy team members had changed the process to add their initials to each of their records, which had previously been anonymous. This was so the pharmacist could establish if everyone was recording mistakes. He said this had led to a significant increase in the data being collected to help inform the monthly analysis and the changes made to reduce risk. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents electronically using DATIX. Pharmacy team members discussed the errors at the monthly patient safety huddle. And, they discussed why the mistake had happened and proposed ways to prevent recurrence. One recent example was making sure fridge items were highlighted during the dispensing process to prevent incorrect storage.

Pharmacy team members explained a change they had made to their system for unpacking stock orders. Previously, stock had been put away before prescriptions waiting for items were dispensed. Now, they sorted received stock in to alphabetical order in baskets on the bench. Pharmacy team

members then dispensed prescriptions waiting for ordered items immediately from the stock received. And, they put any stock left over away on the shelves once the prescriptions had been completed. Pharmacy team members said the new system helped them to dispense items waiting for stock more quickly for people. And, the system reduced the risk of picking errors. They explained that the risk was reduced because it was likely that the stock order only contained the medicine, form and strength that they had ordered. They explained that when picking from the shelves, there was more risk of them picking the wrong strength of the same medicine or a different similarly named or packaged medicine by mistake. Pharmacy team members continued to check stock that remained on the shelves to make sure it had not expired and was safe to supply.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires and from regular reports of mystery shopper visits. Pharmacy team members gave an example of feedback after a recent mystery shopper visit. It had been highlighted that it could take some time for them to acknowledge and serve customers. So, pharmacy team members had changed their process to at least acknowledge someone coming in to the pharmacy if they were busy. And, they had adjusted the staff rotas to try and always have someone at the pharmacy counter.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins. The bins contained bags which were sealed when they were full. And they were collected by a specialist contractor and destroyed securely. Pharmacy team members had been trained to protect privacy and confidentiality. They completed training via the eExpert online training system each year. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR).

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding contacts for advice. The pharmacy had contact details available for the local safeguarding service. Pharmacy team members had trained via the documented procedures and by verbal instruction and training from the pharmacist. The pharmacist completed training via the Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the right skills and qualifications for their roles and the services they provide. They complete training regularly. And, they discuss any learning needs with their manager. Pharmacy team members talk together openly to manage the workload and improve ways of working. And they have group discussions about why mistakes happen, to help inform the changes they make to help prevent mistakes happening again.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist manager and three dispensers. The pharmacist explained that staff rotas had been redesigned recently after staff hours had been reduced. He had negotiated with the remaining team. And, some pharmacy team members had adjusted their working hours to accommodate the gaps to provide adequate staffing levels. Pharmacy team members completed training via the eExpert online training system and by regular discussions with the pharmacist and pharmacy team members. They received training modules to complete about various subjects each month. And, these included new procedures and their associated assessments. The pharmacy had an appraisal process. Pharmacy team members received an appraisal with the manager every year. Before each appraisal, pharmacy team members completed a self-assessment about their own performance over the last year. They discussed their responses with the manager during their appraisal meeting. Then, they agreed and set objectives to address any learning needs. A dispenser gave one example of an objective she had set to improve her knowledge and confidence with over-the-counter medicines. She explained that she was learning by reading about different products, by teaching from the pharmacist and by listening and observing other colleagues during consultations with people.

Pharmacy team members communicated with an open and effective working dialogue during the inspection. Their interactions were professional. And, it was clear that they were comfortable working together to provide the best service they could. Pharmacy team members said they felt comfortable and confident to discuss any issues openly with each other about any aspect of the pharmacy operation. A dispenser explained she would raise professional concerns with the pharmacist or area manager. She said she felt comfortable raising such a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And, pharmacy team members knew how to access the procedure. Pharmacy team members explained a change they had made after they had identified areas for improvement. The pharmacy had recently undergone a refit. They explained that after the refit, they carefully considered where medicines were to be stored. And, they had moved inhalers out of the drawers and on to a shelf. They explained that the change meant that inhalers, which were commonly dispensed, were easier to see and access. And, they were now able to dispense them more quickly without disturbing colleagues standing in front of the drawers. The company asked the team to achieve targets in various areas. For example, the number of prescriptions dispensed, the volume of over-the-counter sales and the number of medicines use review and new medicines service consultations completed. The pharmacist explained that he felt supported by the area manager to achieve the targets. And, he was confident that he could ask the area manager for help if necessary. He said that pharmacy team members from other local branches were available to help train staff and support team improvement if required.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door. And, the room was kept locked when not in use. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet with a sink, which provided hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easily accessible to people. And, it provides its services safely and effectively. Pharmacy team members embrace new technology and ways of working. And they have the appropriate checks in place to monitor any changes in risks to the pharmacy's processes. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines. And to identify what they look like. Pharmacy team members identify people taking high-risk medicines. And, they provide these people with advice to help them take these medicines safely. The pharmacy sources and stores its medicines appropriately. And it mostly manages its medicines effectively.

Inspector's evidence

The pharmacy had level access from the car park and from the surgery reception area. Pharmacy team members said they would ask people about the best way to help them if possible. The pharmacy had a hearing induction loop for people who used a hearing aid. Pharmacy team members said they would also use written communication with people who had hearing impairment. And, they would provide large print labels and instruction sheets to people with visual impairment.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And, they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and the patients leaving without all their prescription. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously.

The pharmacy sent a good proportion of its prescriptions to the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. The pharmacist explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. He said that it took three days for prescriptions to be processed and medicines to be returned from the hub. So, the pharmacy continued to dispense prescriptions for urgent acute items, such as antibiotics, medicines stored in the fridge or prescriptions for unusual quantities of medicines. The pharmacist said prescriptions sent to the hub were most commonly for people's regular repeat medication. He also explained that part of the prescription could be sent to the hub for assembly. And, the other parts, unsuitable for the hub, could be dispensed in the pharmacy. When a prescription was received, pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. Then, they generated the dispensing labels. The labels for items to be dispensed in the pharmacy were printed. And, the labels for medicines assembled at the hub were sent to the hub pharmacy electronically. Once labelled, the prescriptions were held in a queue for the pharmacist to perform a clinical and accuracy check. The pharmacist

logged on to the system to perform the necessary checks. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. Only the pharmacist, using their personal smart card and password, were able to perform the clinical and accuracy check and release prescriptions to the hub. Once released, pharmacy team members dispensed and packaged any medicines that were unsuitable for the hub. And, they filed the prescriptions ready for the hub medicines to be received. Two days later, the pharmacy received the items dispensed at the hub. It received the medicines in sealed packages. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared. And, the bags were scanned on to shelves ready for collection. The pharmacist explained that when the hub systems was being implemented at the pharmacy, the pharmacy team members had carried out an audit of 300 prescriptions returned from the hub. He explained that all 300 bags were opened when they were returned to the pharmacy. And, he had performed a final accuracy check of all items. He said that during the audit phase, he did not identify any errors made by the dispensing robot at the hub. The pharmacy continued a daily quality assurance (QA) check of the items received from the hub. From the items received, the pharmacist opened one bag at random and performed an accuracy check against the prescription. The pharmacist recorded the daily QA check. And, any issues identified were reported to the superintendent pharmacist's (SI's) office. The pharmacist said that implementation of the hub system had helped to reduce the pressure on the team. And, he said it had helped to generate quality time for him to spend in consultations with patients or supporting pharmacy team members, without having to worry about checking lots of prescriptions.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take the medicines. And, it included descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's medication event diary. Pharmacy team members used a workload tracker to keep a record of where each pack was in the dispensing process. They explained that this helped them to establish various key pieces of information easily, such as whether prescriptions had been ordered and received, whether packs had been labelled and assembled and whether there were any queries about someone's medication.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. They used colour coded baskets to identify prescriptions with different priorities, for example whether the prescription was for delivery or whether the patient was waiting in the pharmacy.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to nine months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members highlighted the shelves in front of the top 50 most popular medicines they dispensed. On each sticker, they wrote on the minimum quantity they needed to keep in stock. They determined the minimum stock quantity by using data provided about how much they used each month. Pharmacy team members said the system had helped to significantly reduce having to owe people the most commonly used items. Pharmacy team members asked people presenting prescriptions for warfarin for the latest blood test results and current dose. And they recorded the information provided and made sure people knew how to take the

correct dose. The pharmacist provided counselling and information to people presenting prescriptions for valproate who might become pregnant. He checked with them whether they were enrolled on a pregnancy prevention programme. And contacted their GP to find out if necessary. The pharmacy also had a stock of information material to give to these people who were prescribed valproate.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in two fridges every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members had completed training about the Falsified Medicines Directive. And, they were checking packs of medicines to make sure tamper evident seals were intact. The pharmacist explained that the necessary scanners were in place to scan medicines packaging. But, the software was not ready. He said he expected the SOPs to be updated when the software issues were resolved. And, pharmacy team members were ready to implement the system.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. Delivery record sheets were folded to help protect people's confidential information when they were asked to sign. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. Pharmacy team members obtained equipment from the licensed wholesalers used and from the company head office. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. The terminals were password protected. And, pharmacy team members had their own, individual login credentials to be able to access the electronic medication records system. Pharmacy team members each had their own NHS smart card. And, they removed their card from the terminal when they had finished using it. The pharmacy stored medicines waiting to be collected in the dispensary, away from public view. It had dispensary fridges that were in good working order. And, pharmacy team members used them to store medicines only. They restricted access to all equipment and they stored all items securely.

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.