General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 84-86 Lincoln Green Road, LEEDS, West Yorkshire, LS9 7SU

Pharmacy reference: 1086112

Type of pharmacy: Community

Date of inspection: 05/09/2019

Pharmacy context

The pharmacy is on a small parade of shops in a suburb of Leeds close to the city centre. The pharmacy dispenses NHS and private prescriptions. And it orders people's repeat prescriptions. The pharmacy delivers medicines to people's homes. And it provides medicines in multi-compartmental compliance packs. The pharmacy supplies flu vaccinations. And supplies of emergency hormonal contraception.

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	3.2	Good practice	The pharmacy has good arrangements for people to have private conversations and consultations with the team. People can take some medicines in a separate area away from other people using the pharmacy.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy provides services that support people's health needs. The pharmacy team works well with other healthcare teams to identify and actively promote the health and wellbeing of the local population. The team identifies the health needs of the different groups that access the pharmacy. And develops services to help support and meet these health needs.
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 the records it needs to by law. The pharmacy has written procedures that the team follows. The pharmacy has appropriate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. 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 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 pharmacy kept the SOPs electronically. The team members accessed the SOPs and answered a few questions to confirm they had read and understood them. The pharmacy received alerts about new SOPs or changes via an internal notification system. 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 electronic records of these errors. And the team member involved recorded their own error. The pharmacist had spent time at Well head office analysing the data from error reports. And used this experience to remind the pharmacy team of the importance of accurate and complete record keeping. The pharmacy team recorded dispensing incidents electronically. And sent the report to Well head office. The pharmacy manager found team members were not always recording the error as they had no access to the computer when they needed to record their mistake. To ensure team members had easy access to the record they now opened the computer programme at the start of each day. And it remained open on the taskbar for the day. The pharmacy undertook monthly and annual patient safety reviews. Recent reviews reminded the team to double check the strength of medication selected. And to double check medicines that looked and sounded alike (LASA). The team members had reflected on the cause of a dispensing incident when they had supplied a person with an out of date medicine. The team members discussed the importance of completing date checks correctly. The team introduced an extra step into the date checking process. This involved asking a colleague to sign that they had seen the completion of the date check. The team members were reminded to check expiry dates when dispensing.

The pharmacy had started using the Well offsite dispensing hub in March 2019. The pharmacists had checked the accuracy of the first 300 prescriptions dispensed at the hub and returned to the pharmacy. After completing this exercise, the team reduced the checking of the prescriptions dispensed at the hub to one from each batch sent to the pharmacy. The team also checked split prescriptions when some medicines were dispensed at the hub and the rest dispensed at the pharmacy. The team members recorded the outcome from these checks. So, they could spot trends or any concerns. To date, the team had not found any errors with the medicines dispensed by the hub.

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.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found 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 didn't display a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy 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. The team understood how to respond when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to deliver the pharmacy's services. And the team members support each other in their day-to-day work. The pharmacy provides all team members with opportunities to complete more training. And it provides feedback to team members on their performance. So, they can identify opportunities to develop their career. The team members share information and learning particularly from errors when dispensing. So, they can improve their performance and skills.

Inspector's evidence

A branch pharmacist covered most of the opening hours. Well relief pharmacists provided support when required. The pharmacy team consisted of a full-time registered pharmacy technician who was also the pharmacy manager, a part-time trainee pharmacy technician, three full-time dispensers and two part-time dispensers. At the time of the inspection the relief pharmacist, the pharmacy manager, and three of the qualified dispensers were on duty. The area manager had nominated the pharmacy manager for the Well manager of the year award. And the manager had reached the final.

The pharmacy manager had experience with helping teams struggling to meet standards and continually deliver safe pharmacy services. So, the area manager had asked the pharmacy manager to spend time away from this pharmacy providing support and training for other teams. This included training and incorporating the procedures for sending prescriptions to the Well offsite dispensing hub. The manager had ensured the team at this pharmacy were trained and competent to help run the pharmacy in her absence.

The pharmacy provided extra training through e-learning modules. And it provided team members with protected time to complete their training. The pharmacy manager kept a list in the dispensary of new training modules. The list included the date the training had to be completed by. And the team members' names. The manager removed each name once the team member had completed the training. The pharmacy manager had arranged extra staff to attend the pharmacy whilst the team completed the training for the offsite dispensing site. The pharmacy held morning team meetings. And it provided performance reviews for the team members. So, they had a chance to receive feedback and discuss development needs. The manager used this opportunity to ask team members to take on new roles. Team members could suggest changes to processes and new ideas of working. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And the pharmacist offered the services when they would benefit people.

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 receive their medicines in private and have confidential conversations with the team.

Inspector's evidence

The pharmacy was secure, clean and tidy. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. And it had boxes of disposable gloves. 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 regularly for private conversations with people. The pharmacy had a separate entrance for people to use when collecting their methadone doses. People collecting their methadone doses were also offered the consultation room. And could receive their doses in the main retail area if that was what they preferred. 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. The pharmacy team works well with other healthcare teams to identify and actively promote the health and wellbeing of the local population. The team identifies the health needs of the different groups that access the pharmacy. And develops services to help support and meet these 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. The pharmacy gets is medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via two step-free entrances. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The pharmacy provided the flu vaccination service and the emergency hormonal contraception (EHC) service against an up-to-date patient group direction (PGD). The PGDs provided the pharmacist with the legal authority to administer the flu vaccine and provide the EHC medicine. The pharmacy had an information leaflet in several languages explaining the flu vaccine service. Following a visit from a local asthma nurse the team worked with people prescribed short acting inhalers to raise awareness of how to use these medicines. And what to do if the person was overusing these inhalers.

The pharmacy provided multi-compartmental compliance packs to help around 83 people take their medicines. People received monthly or weekly supplies depending on their needs. One of the qualified dispensers managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team kept at list of people using the service. And used this to track prescription requests and to mark when the team completed the different stages of preparing the packs.

The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The team received a small number of prescriptions as repeat dispensing. So, they could access the prescriptions when required rather than waiting for the GP team to send them. The pharmacy team had spoken to other GP teams about the benefit of having prescriptions for this service sent as repeat dispensing. 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 a room to the rear of the main dispensary to dispense the medication. This was away from the distractions of the retail area. The team usually recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The pharmacist bagged the packs after completing the final check. And attached the prescription to the bag. The team members recorded when the person had collected their packs. So, they could identify people who were not collecting the packs and contact them to find out why.

The pharmacy kept a variety of packs to meet the needs of the person receiving the packs. For example, the pharmacy had packs with deep sections for people with several medicines. So, the person could easily remove the medicines. The deep sections also helped the pharmacist see the medication when

they were checking the packs. The pharmacy had packs with coloured sections indicating the time of day the medicine was to be taken. Some packs were serrated to enable the person to take a day's supply of medicine out with them. 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. And liaised with the GP teams to request new prescriptions when required. The team kept the discharge summary for reference and updated the medication list with any changes.

The pharmacy provided methadone and buprenorphine as supervised and unsupervised doses. The team prepared the sugar-free version of methadone doses using an electronic pump. The pump was linked to a laptop that the team updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy the team selected them from the laptop. And sent the dose to the pump to pour in to a cup for the person to take. The team asked the person to confirm their date of birth and the dose they were expecting before supplying the methadone. This acted as a check that the team member had selected the correct person. The pharmacy used baskets labelled with the person's name and address to hold prepared doses of buprenorphine and the sugar version of methadone. The team kept these baskets in the controlled drugs cabinet.

The team members provided a repeat prescription ordering service. They had an electronic system to remind them when they had to request the prescription. And used this 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 regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The pharmacy team reported concerns to the GP team about people ordering their medicines earlier than needed. The GP teams appreciated this information. And asked the pharmacy team to continue monitoring these requests and report back any concerns, especially any involving medicines that may be abused. The pharmacy manager had shared this monitoring with the area manager who advised other teams to consider adopting this.

The pharmacy sent around 40% of its prescriptions to the Well offsite dispensing hub. The team used a programme within the electronic patient record system (PMR) to enter the prescriptions for sending to the hub. The PMR generated information for the pharmacist such as medicine interactions. So, the pharmacist could refer to this when doing a clinical check of the prescription. The team placed the prescription in a clear wallet with the generated interaction labels. And then placed the prescriptions in a basket for the pharmacist to do a clinical check. The prescription could not be sent to the hub until the pharmacist had done a clinical check. The pharmacist had a password for accessing the PMR to do the clinical check. This ensured the clinical check was only done by a pharmacist. The hub did not dispense medicines such as controlled drugs and split packs. The system issued an alert if the prescription included medicines not dispensed at the hub. So, the pharmacy team were aware and would dispense these medicines. The team had a procedure to ensure prescriptions for the same person that were split between the hub and the pharmacy were supplied together to the person. The hub returned the dispensed prescriptions to the pharmacy two to three days after receiving the prescription. The hub sent the medicines in a bag sealed with a bar code. The team members attached the prescription to the bag. And before putting the bag on the shelves to await collection they scanned the bar code on the bag and the bar code on the shelves holding the completed prescriptions. When the person came to collect their medicines, the team put the person's name into the scanner. This revealed the shelf number holding the completed prescription. The team then scanned each bag for the person to check they had selected the correct one. The team found this system had reduced hand-out errors. The pharmacy had a text messaging service to inform people when their repeat prescriptions and owings were ready. The pharmacy only sent the text message when it had all the medicines for the person ready for supply.

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 team members used this as a prompt to check what they had picked. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had referred a person who met the PPP criteria to their GP. The pharmacy had the PPP pack containing information to give to people.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. 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 kept a record of the delivery of medicines to people. This included a signature of receipt from the person receiving the medicine. The pharmacy obtained separate signatures for CD deliveries. The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a 'use this pack first' sticker 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 pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (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 equipment and installed computer software to meet the requirements of the Falsified Medicines Directive (FMD). But the software was not fully FMD compliant. The team had received FMD training. 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.

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 reference 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 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. And it kept the computer screen in the consultation room locked when it wasn’t being used. The pharmacy stored completed prescriptions away from public view. And it mostly held private information in the dispensary and rear areas, which had restricted access. Completed consent forms containing people’s private information were in a folder on open display in the consultation room. The team members used cordless telephones to make sure telephone conversations were 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.