General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cottingley Pharmacy, 3 Cottingley Vale, Cottingley, LEEDS, West Yorkshire, LS11 0JY

Pharmacy reference: 1087989

Type of pharmacy: Community

Date of inspection: 24/06/2021

Pharmacy context

This community pharmacy is in a large estate in a suburb of Leeds. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help several people take their medicines. The pharmacy was inspected during the COVID-19 pandemic.

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 mostly identifies and manages the risks associated with its services including the risks from COVID-19. The pharmacy team members respond appropriately when errors occur. They discuss what happened and they take suitable action to prevent future mistakes. The team members demonstrate a clear understanding of safeguarding the safety and wellbeing of children and vulnerable adults. And they respond promptly and suitably when concerns arise. The pharmacy has written procedures that the pharmacy team follows. But these are overdue a review so may not contain up-to-date information.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments for all team members to identify their personal risk of catching the virus. The pharmacy had a policy of limiting the number of people in the pharmacy. Its windows displayed several COVID-19 information posters including one reminding people to wear a face covering. And one asking people to follow social distancing requirements. The team reported most people complied with the requirements. The pharmacy had installed plastic screens on the pharmacy counter to provide the team with extra protection. And a bottle of hand sanitiser was on the pharmacy counter for people to use. The team wore Personal Protective Equipment (PPE) masks. The dispensary was small but the team mostly adhered to social distancing requirements. The pharmacy provided some post office services. It had reduced the hours the post office services were provided to help the team manage the pharmacy workload. And to reduce the number of people in the pharmacy. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and many tests had been supplied.

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs were due to be reviewed in February 2019 but the review had not been completed. Not all team members had signed the SOPs signature sheets to show they understood and would follow the SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. They referred queries from people to the pharmacist when necessary.

On most occasions the pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these errors known as near miss errors. The details recorded generally enabled the team to identify patterns and learn from the error. However, the section to record the actions taken to prevent the error from happening again had the same responses for each entry. The actions recorded were either the team member involved had been spoken to or the error had been corrected. This meant the team member didn't have the opportunity to record their thoughts on how to prevent the error from happening again. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included recording the incident on a specific template. The pharmacist manager reported there had not been any recent dispensing incidents. The pharmacy displayed a range of posters alerting the team to medicines that looked and sounded alike (LASA). The posters prompted the team to check the medicine they'd selected when dispensing. Team members also alerted each other to medicine packaging with similar appearance. The pharmacy had a procedure for handling

complaints raised by people using the pharmacy services. The team members received several positive comments from people for the help they'd provided during the pandemic.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The CD registers were kept electronically. The system captured the current stock balance for each CD register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. The pharmacy had procedures for managing confidential information and the team was aware of the requirements of the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in the retail area for people to see. The team separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures and guidance for the team to follow and team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members had recently completed suicidal awareness training and knew of the Ask for ANI (action needed immediately) initiative. The team responded well when safeguarding concerns arose. The delivery drivers reported concerns about people they delivered medication to back to the pharmacist who took appropriate action. This included contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with a range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. Pharmacy team members receive some informal feedback on their performance and they have a few opportunities to complete ongoing training. This means they may find it harder to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist manager, a pharmacy pre-registration student, a full-time dispenser, a part-time medicines counter assistant (MCA) and a new starter who worked full-time. The new team member had recently been enrolled onto the combined dispenser and MCA course. The pharmacy employed two part-time delivery drivers. At the time of the inspection the pharmacist manager, the dispenser and new starter were on duty.

The new team member had received internal training and was supervised by the experienced team members. The new team member was provided with regular feedback on their progression and understanding of the pharmacy's procedures. The pharmacy provided the team with some additional learning through online training modules to help them keep their knowledge up to date.

The pharmacy didn't provide formal performance reviews for the team members. This meant there was limited chance for team members to identify their training needs and discuss any development requirements. The team members occasionally received informal feedback from the pharmacist manager particularly after a person using the pharmacy had commented on the service provided.

The pharmacy held team meetings and team members could suggest changes to processes or new ideas of working. And give feedback on how pharmacy services were being provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. The pharmacy has suitable arrangements to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. It had separate sinks for the preparation of medicines and hand washing. The dispensary was small with limited space to work. The team managed this by working in an organised manner and keeping floor spaces clear to reduce the risk of trip hazards. The pharmacist manager discussed the plans the owner had to extend the premises to improve the space available for the team to work. The pharmacy had restricted access to the dispensary during the opening hours.

The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a small, soundproof consultation room which the team used when providing services such as the flu vaccination. During the pandemic the team occasionally used this for private conversations with people. And cleaned the room after use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it suitably manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and the team generally carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and the window displays detailed the opening times. The team provided people with information on how to access other healthcare services when required. 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 as required with the prescription wrapped around. The person was asked to confirm their details before the dose was handed over. The GPhC had received a concern about the pharmacy's method of disposing of the containers after the person had taken their dose. The team members were observed taking appropriate action with the container including removing the dispensing label for shredding. And safely disposing of the container.

The pharmacy provided multi-compartment compliance packs to help around 40 people take their medicines. The pharmacy team managed the workload to ensure people received the correct medication and in time to take their doses. The team divided the preparation of the packs and usually ordered the prescriptions one week before supply. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. The pharmacist manager was liaising with the team at the medical centre to provide prescriptions in the electronic repeat dispensing format. So, the pharmacy team would have quicker access to prescriptions. The team kept a record of the receipt of the prescriptions and when the packs were completed. This meant all team members knew what stage the preparation of the packs was at. The team recorded the descriptions of the products within the packs and it supplied the manufacturer's information leaflets. This helped people to identify the medicines in the packs and to have information about their medicines. The pharmacy received copies of hospital discharge summaries that the team checked for changes or new items.

The pharmacy provided medicines to two intermediate care centres. People admitted here had been discharged from hospital and stayed here before they returned home. The nurses at the centres ordered the prescriptions and the pharmacy team supplied the medication within two days of receiving the prescription. Occasionally the centres asked for prescriptions to be urgently sent and sometimes sent faxed copies of the prescriptions. When the prescription was for CDs the pharmacist arranged for the prescription to be sent to the pharmacy rather than faxed. If the supply was outside the delivery driver's usual working hours the pharmacist delivered the medication after work.

The team provided people with clear advice on how to use their medicines. When the medication brand changed the team informed people verbally or wrote a note about the change and sent it with the medication. This helped to assure people that whilst the medication may look different it was the same as they had previously had. The pharmacist recorded conversations with people about their medication on to the pharmacy's electronic record (PMR). The pharmacist had contacted the local medical centre teams on a few occasions as part of the NHS discharge medicines service. The pharmacist advised the medical centre teams that the prescriptions sent to the pharmacy did not have the medication and

medicine doses listed on the person's discharge information. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and had PPP information to provide people with when required.

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. 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 found that the team completed the boxes. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 the delivery driver did not ask people to sign for receipt of their medication except for CDs.

The pharmacy obtained medication from several reputable sources. The team kept medication removed from the original packs in bottles. And usually labelled the bottles with details of the medication inside and the batch number and expiry date of the medicine. However, a few bottles were found without this information on the label. This meant the team members would not know if the medication was in date. And they couldn't identify if the bottle contained affected stock if a safety alert came through. One medicine had been over-labelled, and the pharmacist subsequently investigated this to ensure compliance by all team members. The pharmacy team checked the expiry dates on stock but didn't keep a record of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range.

The GPhC had received concerns about the use of medication returned to the pharmacy. The team was observed to appropriately handle medication returned to the pharmacy. This included removing people's confidential information and placing the medication in an appropriate medicine waste bin. The pharmacy 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 received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually 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 it uses its facilities to suitably protect 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 had a range of CE equipment to accurately measure liquid medication. And it used separate, marked cylinders for specific liquids to prevent cross-contamination. The pharmacy team used a fridge to store medicines kept at these temperatures.

The pharmacy 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 private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.