General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Woodroyd Pharmacy, Woodroyd Health Centre, Woodroyd Road, BRADFORD, West Yorkshire, BD5 8EL

Pharmacy reference: 1091742

Type of pharmacy: Community

Date of inspection: 01/11/2022

Pharmacy context

The pharmacy is adjacent to a health centre in the suburbs of Bradford. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide medicines in multi-compartment compliance packs for some people. And they deliver medicines to people's homes. The pharmacy provides a seasonal flu vaccination service to people. And it provides people with some travel vaccinations.

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 adequately identifies and manages risks to its services. It has the written procedures it needs relevant to its services. Pharmacy team members consider the risks of providing services to people. But they don't record these assessments to help with ongoing risk management. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss most of the mistakes they make so that they can learn from them. But they don't always capture key information in these records, so some learning opportunities may be missed.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks associated with its services. The superintendent pharmacist (SI) had reviewed the SOPs in 2021. Pharmacy team members had signed to confirm they had read and understood the procedures since the last review. The SI had set a date to review them again in 2023. The pharmacy did not have any documented risk assessments in place for its flu or travel vaccinations services. This was discussed, and the SI explained they had considered and mitigated various risks associated with delivering the services. But they had not documented these assessments. The SI demonstrated some of he risks that had been considered, such as making sure the pharmacy's consultation room was suitable, making sure that the necessary equipment was available to deal with an emergency., and ensuring that pharmacy team members were properly trained. The pharmacy had SOPs in place for each vaccination service. Team members delivering vaccinations had been properly trained, and up-to-date training certificates were available to confirm this.

Pharmacy team members usually highlighted and recorded near miss and dispensing errors they made. There were documented procedures to help them do this effectively. But they admitted that they did not always record every near miss they made. They gave assurances that they always discussed their errors and considered why they might have happened. And they used this information to make changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline, to help prevent the wrong medicines being selected. The records available contained little or no information about why mistakes had been made, often stating "rushing" as a cause. Or the changes team members had made to prevent them happening again. The SI looked at the data collected ad hoc to establish any patterns of errors. And they discussed the patterns found with the team. But the SI did not have a formal process for analysing errors. And they did not record their analyses. This meant they might miss out on opportunities to reflect, learn, and make improvements to the pharmacy's services. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. The records seen were comprehensive and gave full account of the mistakes made, the causes and the changes made by pharmacy team members to help prevent a recurrence.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It collected feedback from people verbally and did not have any records of any feedback received. A team member gave an example of improving the pharmacy's stock of bandages and first aid equipment available for people to buy after receiving feedback. The pharmacy had up-to-date professional

indemnity insurance in place. It maintained a responsible pharmacist record which was complete. The pharmacy kept controlled drug (CD) registers electronically, that were complete and in order. It kept running balances in all registers. These were audited against the physical stock quantity approximately weekly, or monthly for methadone. The inspector checked the running balances against the physical stock for three products. And these were all found to be correct. The pharmacy kept private prescription and emergency supply records, which were complete and up to date.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. These bags were collected periodically by a waste disposal contractor and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information correctly. Team members explained how important it was to protect people's privacy and how they would protect confidentiality, including using different parts of the pharmacy to have sensitive discussions with people when necessary. The pharmacy had a documented procedure for dealing with concerns about children and vulnerable adults. And some printed guidance materials and local contact information for team members to refer to. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And they explained how they would refer any concerns to the pharmacist. Some pharmacy team members had completed safeguarding training in 2021. But some team members had not yet completed training. The SI had last completed training in 2014. The SI gave their assurance that all team members would complete or update their training as necessary as soon as possible.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete some ongoing training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the pharmacy team members present were the superintendent pharmacist (SI), two pharmacy technicians who were trained to perform the final accuracy check of prescriptions, one dispenser, two trainee dispensers, a trainee medicines counter assistant, and a delivery driver. All had completed appropriate training for their roles and also completed ad hoc ongoing learning. One recent example was an online training course about dementia. Team members also regularly discussed learning topics informally with the SI and each other. And the SI provided information or signposted them to relevant materials and resources to help answer their questions. The pharmacy had an appraisal process in place whereby team members had a meeting every year with the SI to discuss their performance and learning needs. And they set objective to address any learning needs identified. One example of a recent objective was for the pharmacy to train other team members to manage and process multi-compartment compliance packs. Packs were currently managed by one of the pharmacy technicians. And this objective meant the technician would have more time to work in other areas of the pharmacy to help develop their knowledge and skills. The technician thought the pharmacy was making good progress training colleagues to manage packs. And this meant they were able to start focussing on areas of their personal development. Team members explained they would also raise any learning needs informally with the pharmacy manager, who would support them to access the right resources to complete their learning.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. They had recently reorganised their system for packaging prescriptions at the end of the dispensing process following a dispensing incident. They modified their audit trail to capture the team members involved and they also replaced broken dispensing baskets that may have contributed to the incident. Pharmacy team members explained that if they had any professional concerns, they would raise them with the SI or the pharmacy's owners. They felt comfortable raising concerns and confident that their concerns would be considered. They explained that if they had a concern they could not raise internally, they would contact the GPhC for advice. The pharmacy did not have a whistleblowing policy for team members to use.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has a suitable room which pharmacy team members use to speak to people privately.

Inspector's evidence

The pharmacy was clean and well maintained. The benches where medicines were prepared were tidy and well organised. And the floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room available, which was clearly signposted. Pharmacy team members used the room to have private conversations with people. 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. The pharmacy maintained heat and light to appropriate levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy has systems in place to help provide its services safely and effectively. It sources its medicines appropriately. And it generally stores and manages its medicines properly. But pharmacy team members do not always provide people with all the appropriate information to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the car park and adjoining GP surgery via an automatic door. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment. Some pharmacy team members spoke languages other than English to help communicate with people in the local community. These included Urdu and Punjabi. Pharmacy team members also used online translation tools to help communicate with people who spoke other languages.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. The pharmacist clinically checked each prescription received in the pharmacy. And the annotated prescriptions to confirm they had completed their checks. A pharmacy technician explained they would not carry out final accuracy checks unless the clinical check had been completed. They also gave clear examples of the types of prescriptions they were not permitted to check, such as prescriptions for controlled drugs and prescriptions for some high-risk medicines, such as methotrexate. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate.

The pharmacy supplied medicines in multi-compartment compliance packs (MDS) when requested. The pharmacy sent most MDS prescriptions to a sister pharmacy nearby. These prescriptions were clinically checked by the pharmacist against the pharmacy's master records each time a prescription was received. Each MDS pack had a sheet attached which gave descriptions of what each medicine looked like and a colour picture of each medicine, so they could be identified. Pharmacy team members documented any changes to medicines provided in MDS packs on the patient's master record sheet. They explained that people received information leaflets about their medicines when they were first prescribed. But leaflets were not routinely provided after that. The pharmacy delivered medicines to people. It recorded the deliveries made. 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. Pharmacy team members highlighted bags containing controlled drugs (CDs) with a sticker on the bag and on the driver's delivery sheet.

The pharmacy obtained medicines from licensed wholesalers. It stored stock medicines on shelves. The pharmacy had disposal facilities available for unwanted medicines, including CDs. Pharmacy team members checked and recorded the minimum and maximum temperatures of the medicines fridge

each day. The temperature records seen were within acceptable limits. Team members recorded checks of medicine expiry dates that they made in various areas of the pharmacy every week on a rolling cycle. This meant they checked all medicines every month. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry. They removed expiring items two months before their expiry. The pharmacy team members responded to any alerts or recalls they received about medicines. They processed any affected medicines found and they recorded the actions they had taken. Some boxes were found on the pharmacy's shelves that contained mixed batches of medicines, which could increase the risk of error. This was discussed with the SI, and they gave their assurance that all mixed batches would be removed immediately. And team members would be retrained about how to properly label medicines kept in the pharmacy if they were removed from their original packaging.

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 people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view.

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.