

Registered pharmacy inspection report

Pharmacy Name:Pharmacycare Direct, 48 Gaisby Lane, SHIPLEY,
West Yorkshire, BD18 1AX

Pharmacy reference: 1091881

Type of pharmacy: Community

Date of inspection: 05/11/2024

Pharmacy context

The pharmacy is in a residential area close to Bradford city centre. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They provide some medicines to people in multi-compartment compliance packs. And they deliver some medicines to people's homes.

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 associated with providing its services. It has written procedures to help team members provide its services safely. Pharmacy team members record and discuss the mistakes they make so that they can learn from them. And they make some changes to help reduce risks. The superintendent pharmacist (SI) understands their role to help protect vulnerable people. And they suitably protect people's confidential information.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) in place, covering most of its services, to help pharmacy team members manage the risks. The SI, who was also the pharmacy owner, had reviewed the SOPs in 2024, and these were due to be reviewed again in 2026. Pharmacy team members had signed to confirm they had read and understood them.

Pharmacy team members recorded mistakes that were identified before people received their medicines, known as near misses. And mistakes identified after people had received their medicines, known as dispensing errors. There were documented procedures to help team members do this effectively. Team members discussed any mistakes and why they might have happened. They recorded some information about each mistake and took action when they identified things they could do to prevent a recurrence. They gave a recent example of separating different strengths of carbocysteine capsules and moving other look-alike and sound-alike medicines to help avoid selecting the wrong product. The SI explained how team members would record and discuss dispensing errors. But there were no recent examples.

The pharmacy had a documented procedure to help team members deal with complaints handling and reporting. It collected feedback from people verbally. But there was no information available for people in the retail area about how to provide feedback. So, people may not always know what to do if they want to raise a concern.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members checked these registers against the physical stock quantity whenever they made an entry. But this meant that registers for medicines not used often were not regularly audited. Team members audited the methadone register each week. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. And it maintained a responsible pharmacist record, which was up to date. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily. And they accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It adequately segregated and destroyed confidential waste. The pharmacy had a documented SOP about confidentiality and data protection available in the pharmacy.

The SI gave some examples of signs that would raise their concerns about vulnerable children and adults. They explained how they would refer to local safeguarding teams. And they would use the internet to find out their contact information. The pharmacy had SOPs for dealing with concerns about

children and vulnerable adults. But the SOP for safeguarding children was dated 2007. And the procedure for vulnerable adults was dated 2013. They had been reviewed by the SI in 2024. But neither had been changed following the review. And both contained out-of-date information, for example by referring to organisations that no longer exist, such as the local Primary Care Trust (PCT). The pharmacy had not provided any formal training for team members about how to handle a safeguarding concern, other than the SOPs. And the pharmacist had last completed training in 2017. So, team members may not always fully understand what they should do if they have any safeguarding concerns.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members receive the right training for their roles and the services they provide. They complete some ad hoc ongoing training to keep their knowledge up to date. And they feel comfortable discussing ideas and issues.

Inspector's evidence

At the time of the inspection, the SI was working alone in the pharmacy, and they adequately managed the workload. The SI explained that when they worked alone, they took a mental break between dispensing and checking prescriptions, to help reduce the risks of missing any mistakes they made. Or they would leave their work for another team member to check later the same day. Pharmacy team members completed training ad hoc by reading various materials and discussing topics with the SI. The SI could not give any examples of any training they had completed recently. The pharmacy did not have an appraisal or performance review process for team members. The SI explained how team members would raise any learning needs informally with them, and they would teach them or signpost them to appropriate resources.

The SI explained that pharmacy team members felt comfortable raising professional concerns with them. The pharmacy did not have a whistleblowing policy. And the SI did not ask pharmacy team members to meet any performance related targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is generally clean and properly maintained. It provides a suitable space for the services provided. And team members adequately use the space to manage people's privacy.

Inspector's evidence

The pharmacy was generally clean and sufficiently maintained. Most areas of the pharmacy were tidy and well organised. The pharmacy's floors and passageways were generally free from clutter and obstruction. But there were some areas of floor that were cluttered with boxes of stock, which increased the risks of tripping. Equipment and stock was kept on shelves throughout the premises. The pharmacy had a private consultation room. But it was being used for storage, so it was not available to have private conversations with people. The SI explained they were usually able to have private conversations with people at the pharmacy's retail counter as there was rarely more than one person in the pharmacy at a time.

The pharmacy had a clean sink in the dispensary used for medicines preparation. It had a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels. The pharmacy's overall appearance was professional.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely and effectively. It suitably sources its medicines, and stores and manages them appropriately to keep them in good condition. And it has some processes to help people understand and manage the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the street. The SI explained how pharmacy team members could use the electronic patient medication record (PMR) system to produce large-print labels to help people who were blind or partially sighted. And they would write a conversation to help people who were Deaf or hard of hearing. But there were no examples of situations where they had used these facilities.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested, to help them take their medicines safely. The pharmacy ordered prescriptions for these packs several days in advance to allow time to deal with any queries or discrepancies. Backing sheets were attached to the packs, so people had written instructions of how to take their medicines. These included descriptions of what the medicines looked like, so they could be identified in the packs. The pharmacy regularly provided people with patient information leaflets about their medicines. Any changes to medicines provided in packs were recorded on the person's PMR. But the records they made did not provide any details about who had requested the changes and why, to help easily deal with future queries, so the pharmacy may not always have a full audit trail to show what has happened.

The pharmacist counselled people receiving prescriptions for valproate if they were at risk. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacist did not record these conversations with people to help with future queries. And the pharmacy did not carry out any regular audits to help identify people at risk. The SI was aware of the need to provide valproate in the manufacturers original packaging.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This provided an audit trail of the people involved in the dispensing process. They used baskets during dispensing to separate peoples' medicines and prescriptions, to help prevent them being mixed up. The pharmacy obtained medicines from licensed wholesalers. It stored medicines tidily on shelves. And it kept medicines in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The CD cabinet was tidy and well organised. And out-of-date and patient-returned CDs were segregated.

The pharmacy delivered medicines to some people. But it did not record the deliveries it made, so it could not demonstrate what had been delivered if there was a concern or a query. The team member making deliveries, which was usually a dispenser, left a note through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy. They also attempted to redeliver medicines if someone was not at home the first time.

Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The records showed the fridge temperatures had been within acceptable limits. Pharmacy team members checked medicine expiry dates every three months, and

they recorded these checks. They highlighted items due to expire in the next six months. And they removed these items during the check before their expiry. The SI explained how they acted when they received a drug alert or manufacturers recalls via email. But they did not record their actions to be able to refer to later.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment available for the services it provides. It manages and uses its equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. It had various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for preparing liquid medicines. It had suitable equipment available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected 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.