General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Midway Pharmacy, 46 Chapeltown, Pudsey, West Yorkshire, LS28 8BL

Pharmacy reference: 1093079

Type of pharmacy: Community

Date of inspection: 27/11/2023

Pharmacy context

This community pharmacy is close to Pudsey Town Centre. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides multi-compartment compliance packs to many people to help them take their medication correctly. The pharmacy provides other NHS services such as the hypertension case finding service. And the Community Pharmacist Consultation Service. It also provides a private ear wax removal service.

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	2.5	Good practice	Members of the pharmacy team have regular appraisals and one-to-one meetings with their manager to identify opportunities to develop their knowledge and skills. Frequent team meetings are held where team members are actively encouraged to discuss and share ideas. They share key learnings from these meetings and new ways of working with other teams to support the safe and effective delivery of pharmacy services.
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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows and it completes the records it needs to by law. Team members protect people's private information correctly and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond suitably to errors by discussing what happened and taking appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of services. The team members accessed the SOPs and answered a few questions to confirm they had read and understood them. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members followed the SOPs when alerted to errors they made when dispensing prescriptions, known as near misses. After being asked to identify and correct their errors the team member completed the electronic near miss record. If the team member involved with the error was not on duty they were informed on their return to work. So, they were aware and could reflect on why it happened. The details captured on the near miss log enabled the team to identify patterns, learn from the errors and take action to prevent similar errors from happening again. A procedure was in place for managing errors that were identified after the person received their medicines, known as dispensing incidents. This included recording the incident and informing all teams members, so they were aware of what had happened and of the actions taken to prevent the error from happening again. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the pharmacy website provided details on how to provide feedback. The pharmacy kept a record of people's comments and feedback for all team members to read.

The pharmacy had current 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 pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. The pharmacy's website displayed details on the confidential data kept and how it complied with legal requirements. Team members had completed training about the General Data Protection Regulation (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles. The delivery driver reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they are good at supporting each other in their day-to-day work. They discuss ideas to enhance the safe delivery of the pharmacy's services. Team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist covered most of the opening hours with locum pharmacists covering the remaining hours. The pharmacy team consisted of a full-time manager who was a qualified dispenser. The manager was a pharmacist registered overseas who was waiting to enrol onto the GPhC's overseas pharmacist course. Other team members included a trainee pharmacy technician, three qualified dispensers and two trainee dispensers. At the time of the inspection all team members were on duty.

Team members had specific roles such as the dispensing of medicines in multi-compartment compliance packs. And the trainee technician had recently taken on additional responsibilities such as completing the balance checks of the CD registers. However, all team members knew how to undertake key tasks and a daily rota allocated tasks amongst the team. This ensured these tasks were completed especially at times when team numbers were reduced such as planned and unplanned absence. The rota also enabled the trainee team members to have protected time at work to complete their training modules.

The team had faced some staffing challenges after experienced team members left. And the pharmacy had increased the number of people it provided multi-compartment packs to following referrals from nearby pharmacies who had reached capacity with this service. Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. The pharmacy manager was new to the role but had experience of working in other pharmacies. During their induction the manager spent time with the Superintendent Pharmacist and senior managers to discuss the impact from changes to the team and its workload. As a result, the manager was supported to introduce new ways of working to help the team deliver an efficient service. And reported that the changes were having noticeable effects in supporting the team with its workload.

Team members used online training modules to keep their knowledge up to date and they had some protected time to complete the training. Team members had received training for the ear wax removal service from a specialist nurse based at Leeds Teaching Hospital Trust. And received training certificates on completing the training. The pharmacy provided performance reviews for team members which gave them chance to receive individual feedback and discuss their development needs. They also had monthly one-to-one sessions with the pharmacy manager.

The pharmacy held regular meetings and team members were encouraged to contribute to the discussions at these meetings. The pharmacy manager used the team meetings to share information from the company so the team was aware of new developments and training. Key points from the team meetings were recorded on a company platform for other team members to be aware of and learn from. This shared learning included the medication list and communication sheets the pharmacy

manager had developed for the team to use for the compliance packs service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were kept tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Heating and lighting were kept to an acceptable level in the dispensary and retail areas.

The team generally kept floor spaces clear to reduce the risk of trip hazards. Occasionally a few baskets containing prescriptions waiting to be checked by the pharmacist were stored on top of each other on the floor. Team members explained this happened when there were several prescriptions being dispensed and the workstations attached to the automated dispensing system reduced the space available for the baskets.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room that was used for private conversations with people and when providing services such as the ear wax removal service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which help people to meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. They generally store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The main entrance to the pharmacy was via a few steps with a handrail and there was a step-free entrance at the rear of the building for people to use. However, this entrance was not advertised so people new to the pharmacy had to advise team members in advance so they could be directed to the alternate access. The team kept a small range of healthcare information leaflets for people to read or take away. And provided people with information on how to access other healthcare services when required. The pharmacy provided its services such as the seasonal flu vaccination service and travel vaccination clinic against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the authority to administer the vaccines. In-date adrenaline was available for the pharmacist to administer when a person experienced an anaphylactic reaction to a vaccine.

The pharmacy provided multi-compartment compliance packs as weekly or monthly supplies to help many people take their medicines. Two team members managed this service with support from other team members. They divided the preparation of the packs across the month and kept a record of the completion of each stage of dispensing the medicines into the packs. Prescriptions were generally issued as electronic repeat dispensing prescriptions. The team requested other prescriptions several days before the packs were dispensed, to give time to manage queries. The pharmacy manager had met with the local GP teams to provide an updated list of people using the service to ensure their medication was aligned. And to share the process for dispensing medicines into the compliance packs to highlight the importance of prescriptions being sent to the pharmacy in time for dispensing. This resulted in CD prescriptions being sent two days before supply which was an improvement. Previously the prescriptions had arrived late in the afternoon on the day of delivery. Each person had a record listing their current medication and dose times. The team checked prescriptions against the list and queried any changes with the GP team. The team also used the record to capture the responses to queries and changes to a person's medication. The list was referred to, along with the prescription, during the dispensing and checking of the prescriptions. The descriptions of the products within the packs were not recorded but the manufacturer's packaging leaflets were supplied. This meant whilst people had information about their medication, they didn't have information to help identify the medicines in the packs. The pharmacy received copies of hospital discharge summaries via the NHS communication platform. Team members had noticed that the discharge summaries were sometimes processed a few days after they had been sent. So, they introduced a system to ensure the pharmacist and one team member were responsible each day for checking the summaries that arrived and to take any necessary action.

The pharmacy dispensed medicines to people living in three care homes in the local area. One of the full-time dispensers managed the service with support from other team members. The care home teams advised the pharmacy of the medicines needed each month for the pharmacy team to send prescription requests. This also enabled the team to check the prescriptions sent from the GP teams

and identify any missed items or changes. The process usually started two weeks before the supply to allow time to manage queries. Completed packs were sent to the care home one week before the next monthly cycle started. This gave the care home team time to check the supply and identify any missing medication. The care homes teams and the GPs updated the pharmacy team with any changes to people's medicines that occurred during the month.

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 stored securely but with no separation between individual doses, which ran the risk of the wrong dose being selected. Team members provided people with clear advice on how to use their medicines and were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). At the time of the inspection no-one prescribed valproate met the PPP criteria. The team was also aware of the new rules requiring valproate to be supplied in the manufacturer's original outer packaging. The computer on the pharmacy counter had access to the electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at.

Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Most medicines were dispensed from an automatic dispensing system that the team accessed from one of three computer stations linked to the system. Each station had a chute leading from the automated system to a basket that held the dispensed medicine. The separate chutes helped to prevent a build-up of dispensed medicines in one area which could increase the risk of errors. Pharmacy team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. Team members stored incomplete prescriptions separately so they could be regularly checked to see if the stock had arrived. And to contact the prescriber to discuss alternate medication if there was a long-term problem with supply. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock and 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 so team members could assess if the medicines remained safe to use. The team checked and recorded fridge temperatures each day and a sample of these records found most were within the correct range. However, on three days the maximum temperatures were greater that the accepted maximum temperature of eight degrees Celsius. Team members were aware of this and reported they'd re-checked the temperatures on these dates and the temperatures were within range. But they had not updated the records with the second reading. At the time of the inspection the temperature was within range. Controlled drugs were stored securely. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were 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 actioned the alert, kept a record and ensured all team members were aware.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it has appropriate systems in place to ensure its equipment is fit for purpose. The pharmacy uses its facilities to suitably 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 information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And fridges for holding medicines requiring storage at this temperature. The pharmacy completed safety checks on the electrical equipment and the team had access to technical support through the head-office team. On the day of the inspection the team had reported a faulty light that morning which was being fixed by a team of engineers during the inspection.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to help ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other confidential information in the dispensary and rear areas which had restricted public access.

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.