General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Armley Pharmacy, 90-91A Town Street, Armley, LEEDS, LS12 3HD

Pharmacy reference: 1112065

Type of pharmacy: Community

Date of inspection: 10/07/2019

Pharmacy context

The pharmacy is amongst a small parade of shops in Armley, a suburb of Leeds. It dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication 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 identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. But not all the team members have signed to say they have read the procedures. This means there is a risk they may not understand or follow correct procedures. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they act to prevent future mistakes. But they don't record all errors or the outcome from reviewing the errors. This means that the team does not have information to identify patterns and reduce mistakes. People using the pharmacy can provide feedback on its services. 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 Some team members had read and signed the SOPs signature sheets to show they understood and would follow them. The delivery driver had not signed the SOPs relevant to their role. The pharmacy had up to date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake, rather than getting them to find it themselves. The pharmacy had a log for the team to record these errors. The log showed entries were limited to one a month. And before January 2019 the last record made was June 2018. A sample of the error records looked at found the team did not capture details of what had been prescribed and dispensed to spot patterns. For example, one entry in May 2019 listed salbutamol with the code 'F' for the wrong form of the drug. But the team member completing the record didn't capture any other information such as the item prescribed. The team members did not always record what caused the error, their learning from it and the actions they had taken to prevent them doing the same mistake again. The entries with actions recorded had the same statement, to read the prescription. The pharmacy didn't keep records of any reviews of the error reports. Or the actions the team took to prevent future errors. The pharmacy had a procedure for managing dispensing incidents. The team could not recall a dispensing incident to provide an example of the actions taken in response.

The pharmacy completed an annual patient safety report. A recent report stated the team had separated products that looked or sounded alike. The report highlighted that team members were checking each other's work before the pharmacist's final check. So, there was an extra step in the dispensing process to pick up any errors. The report stated that the dispensary team were supervising the delivery driver. The team introduced this following incidents when the delivery driver had taken medicines not due for delivery. Or had picked up bags that had the wrong address details for the person. The driver now asked one of the dispensers to verify medication retrieved from the collection box or the fridge. Or got the dispensers to hand over the supply. The report stated this would improve the safe delivery of medicines. And ensure the right person got the correct medication. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. 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 recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they mostly met legal requirements. But the time the pharmacist signed out as the Responsible Pharmacist was not always recorded. Records of private prescription supplies looked at found that the prescriber's details were often missing. 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 some 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 into a dedicated bag which the pharmacist owner took to another pharmacy in the company for shredding.

The pharmacy team had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team responded appropriately when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the qualifications and skills they need to provide safe and efficient services. They are also given opportunities and encouragement to undertake further qualifications. And to develop their skills. The team members receive feedback about their performance. And they discuss how they can make improvements.

Inspector's evidence

The regular locum pharmacists covered most of the opening hours. The pharmacy team consisted of two full-time qualified dispensers, one part-time qualified dispenser and a full-time pharmacy apprentice doing the combined dispensing and medicines counter assistant (MCA) training. The team split the shifts between them. The pharmacy also had a full-time delivery driver who worked Monday to Friday. The team undertook deliveries at the weekend if the person needed their medicine before Monday.

One of the dispensers had started at the pharmacy as the delivery driver. And with encouragement and support had trained as a MCA and then a dispenser. This dispenser had discussed the pharmacy technician training with the pharmacy owner. The pharmacy provided the team with limited additional training. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback. But this was often a one-way conversation from the team member's line manager. Rather than opening it up for the team member to discuss their performance and development needs. One of the dispensers was asked to take on more roles when the previous manager had left. This included managing the stock for the retail area. The dispenser had been given extra hours to cover this.

The team held occasional meetings and could suggest changes to processes. This included one member of the team setting up the email system for ordering repeat prescriptions. This provided the team with clearer information for tracking prescription requests. One of the dispensers had suggested changing the process for claiming electronic prescriptions from the end of the day to the time the person received the supply. So, the team could see this had happened if a query arose. The team members spent time at the change of shifts to share key pieces of information or jobs they had to complete. They also used a diary to record this information for all the team to be aware of.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, generally secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was hygienic. It had separate sinks for the preparation of medicines and hand washing. The team usually 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 small consultation room. The team used this for private conversations with people. The pharmacy was planning to refit the retail area to include a larger consultation room. The pharmacy had a hatch from the dispensary in to the consultation room. The team used this to pass people their methadone doses. So, this was out of sight of other people in the retail area.

The premises were secure. There was 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services adequately. It takes care when dispensing medicines into multi-compartmental compliance packs to help people take their medication. The pharmacy delivers medication to people's homes. But it doesn't always get people to sign for the receipt of their medicines. So, it may be difficult to resolve any queries or know the person received their medicine. The pharmacy gets its medicines from reputable sources. And it generally stores and manages its medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a ramp and steps both with handrails. The window displays detailed the opening times and the services offered. 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 pharmacy provided multi-compartmental compliance packs to help 60 people living at home take their medicines. And it provided this service to people living in two care homes. One of the full-time dispensers managed the service with support from other team members. The pharmacy had a list of people living at home who received the packs and the day their packs were due. The team ordered prescriptions in advance. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The care home teams ordered the prescriptions. One care home team sent the pharmacy team details of the medicines they had ordered. So, the pharmacy team could check the prescriptions and spot missing items. The other care home did not do this.

Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the GP team. The team prepared most packs as four weeks together using the first weekly prescription. The weekend pharmacist checked the dispensed packs using the first prescription. And the pharmacist on duty when the prescription arrived for the week's supply did the final check of the pack against this prescription. The team were reminded to check the medication list against the most recent prescription before preparing the packs. The team marked the packs to show this happened. The pharmacy team sometimes recorded the descriptions of the products in the packs to help people identify their medicines. And it supplied the manufacturer’s patient information leaflets. 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. The team rarely received communication from the GP teams about changes. The pharmacy team members only knew of the changes when they received the prescriptions. And they checked them against the medication list. The team had asked the GP teams to communicate changes to the medicines supplied in packs via a telephone call and on the change of medication form. So, the team had a record of this. The pharmacy used baskets labelled with the person’s name to hold completed packs, the medication list, the prescriptions and empty packets of the dispensed medicines.

The pharmacy provided methadone and buprenorphine as supervised and unsupervised doses. The team prepared the methadone doses using a Methameasure pump. The pump was linked to a laptop that the team updated with the methadone doses on receipt of a new prescription. The system included a photograph of the person. 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 pharmacy team added the date of receipt for new prescriptions. And the number of prescriptions sent for each person. The team used this when people queried their prescriptions. The team scanned the prescriptions as well as keeping them in alphabetical order in dedicated folders. So, the team members could easily find the prescription when queries arose. The pharmacists prepared buprenorphine doses in advance. This reduced the work pressure of dispensing at the time of supply. The team had introduced collection times to address the issue of several people presenting at the start of the day. This had put pressure on the team to start the Methameasure pump and get the doses ready. The pharmacy displayed a poster advising people that the collection times were from half an hour after opening and up to an hour before closing. The poster listed the opening hours. So, people knew when they could collect their medicine. The team had informed people of this change a month before implementing it.

The pharmacy provided a repeat prescription ordering service. The team usually ordered the prescriptions two days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team sent most requests via email. This provided it with an electronic record and audit trail. This also allowed the team members to download the electronic prescriptions in small batches which helped them manage the workload. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy provided one-off prescriptions to a local care home. The team members did not supply the regular medicines to the care home. So, they didn't know what other medicines the people living in the care home took to enable them to spot any interactions. The team had not asked for copies of administration charts which could provide this information. The pharmacy team didn't know if an audit had been done to see if there were people prescribed valproate in response to the Pregnancy Prevention Programme (PPP). The team members had received PPP training and stated that they were not aware of anyone within the PPP category. The pharmacy had the PPP information to provide to people when required. And a poster in the dispensary reminded the team of the PPP requirements.

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 baskets were different colours which the team used to prioritise dispensing. For example, the team did prescriptions for people waiting for their medicines before prescriptions for delivery items. The team members referred to the prescription when selecting medication from the storage shelves. This helped to ensure they picked the correct item. 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 usually completed the boxes. The pharmacy used clear bags to hold dispensed controlled drugs and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And it kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a system to prompt the team to check that supplies CD prescriptions were within the 28-day legal limit. This system didn't apply to all CDs that had this restriction.

The pharmacy kept a record of the delivery of medicines to people. The delivery driver had a sheet to record when they had handed over the medication to the person. The record included a section to capture a signature of receipt from the person or their representative. The delivery driver didn't always get a signature to prove that they had handed over the medication. Some entries on the signature sheet stated that the driver posted the medicine. The pharmacy had verbal consent from the person for this. But it had no written record from the person to confirm this was safe to do. Such as no pets or children at the address who could be at risk of taking the medicine.

The pharmacy team checked the expiry dates on stock. And kept a record of this. 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 for one of the two fridges. A sample looked at found they were within the correct range. The team didn't record fridge temperatures for the smaller fridge holding dispensed medicines awaiting supply. The temperature for this fridge during the inspection was in 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) from in date stock in a CD cabinet that met legal requirements. The pharmacy team used denaturing kits to destroy CDs.

The pharmacy had installed scanners to meet the requirements of the Falsified Medicines Directive (FMD). But the team were not using them. The pharmacy didn't have any FMD procedures. And the team hadn't received any 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 and actioned it.

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. The pharmacy had two fridges to store medicines kept at these temperatures. Both fridges had a glass door to enable the team to view stock without prolong opening of the door.

The pharmacy computers were password protected and access to peoples' 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 which had restricted access. The team used cordless telephones to make sure telephone conversations were held in 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.