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: 12/09/2022

Pharmacy context

This community pharmacy is on the main street in a large suburb of Leeds. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. The pharmacy provides many people with multi-compartment compliance packs to help them take their medicines. The pharmacy provides the seasonal flu vaccination service and an earwax 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	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 generally identifies and manages the risks associated with its services. The pharmacy completes the records it needs to by law and it provides the pharmacy team members with training and guidance to help them respond to safeguarding concerns. The team members act appropriately when mistakes happen. But they don't keep full records of mistakes or the outcomes from reviews, so they can learn and improve their practice.

Inspector's evidence

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 had review dates of 2021 and most of them had been reviewed at this time, but the SOPs didn't detail the name of the pharmacy. The team members had read the SOPs but not all the team members had signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing process, known as near misses. This included a template to record the near miss error. The pharmacist asked the team member involved to identify the error, reflect on the error and to record it. A sample of near miss error records found the team didn't always record their near miss. The completed entries showed details such as the reason for the error and what the team member had learnt from the error to prevent it from happening again. The pharmacy had a procedure for managing errors that reached the person, known as dispensing incidents. This included completing a report of the dispensing incident on to the NHS Learn from patient safety events service. The pharmacist discussed the dispensing incident with all the team so everyone was aware and could learn from it. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. But it didn't provide people with information on how to raise a concern with the pharmacy team.

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 pharmacy did not display details on the confidential data it kept and how it complied with legal requirements. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures and guidance for the team members to follow and they had access to contact numbers for local safeguarding teams. The pharmacist had up-to-date level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And she responded well when safeguarding concerns arose. The delivery driver reported concerns about people they delivered to back to the pharmacy 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 the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services. The team members have some opportunities to receive feedback and complete training to develop their knowledge and skills.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of one full-time trainee pharmacy technician, two full-time dispensers, one trainee pharmacy apprentice in post a few days, two part-time pharmacy students and a part-time delivery driver. One of the dispensers had previously worked at a dispensing doctors practice so was undertaking the medicines counter assistants course. The team split themselves between the main dispensary at the front of the pharmacy and the rear dispensary where multi-compartment compliance packs were dispensed and stored. The team members worked well together and supported each other especially after their workload had increased following the closure of a nearby pharmacy. The team members completed ongoing training and the pharmacist manager kept the training certificates for each team member in dedicated folders. The team members were offered protected time to complete the training at work.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the team suggested installing more shelves in the room where the compliance packs were prepared so they could be safely stored and easily accessed. This had recently been completed. The team members used a communication book to ensure key pieces of information were shared amongst them. This included contact from a person's GP regarding changes to their medication. The pharmacy didn't provide team members with formal performance reviews to give them a chance to receive individual feedback and discuss their development needs. The pharmacy manager gave the team informal feedback when appropriate. And the trainees had regular one-to-one meetings with the pharmacist manager to discuss their training and any support they may need.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises had undergone a significant refit since the last inspection. This created more space for the team to work and enabled the team to easily engage with people presenting at the pharmacy counter. The pharmacy was tidy and hygienic, it had separate sinks for the preparation of medicines and hand washing. The pharmacy had recently built a soundproof consultation room which the team used for private conversations with people and when providing services such as the seasonal flu vaccination. The pharmacy also had a separate, cordoned off area that provided privacy to people receiving their medication as a supervised dose or when accessing the needle exchange service. The pharmacy had restricted access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

People accessed the pharmacy via a step-free access and provided suitable seating for people waiting for their prescriptions to be dispensed. The computer on the pharmacy counter had access to the pharmacy's electronic patient medication records (PMR). So, when a person presented the team member could check what stage their prescription was at. The team provided people with clear advice on how to use their medicines. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and they knew what information to pass on to people who met the PPP criteria.

The pharmacy provided a travel clinic that included the administration of vaccines after a consultation with the pharmacist, and it was a yellow fever vaccination centre. The pharmacist manager was the trained vaccinator for the service which was provided against up-to-date patient group directions (PGDs). These gave the pharmacist the legal authority to administer the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 130 people take their medicines. The team used a room to the rear of the pharmacy to dispense the prescriptions as it was away from the distractions of the retail area. One of the full-time dispensers managed this service with support from other team members who had been trained to prepare the packs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered and received prescriptions in advance of supply to allow time to deal with issues such as missing items. 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 picked the stock before dispensing the items into the packs and asked the pharmacist to check the items picked. This helped to identify errors before the medicine was removed from the original packaging. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The team kept the completed packs in baskets labelled with the person's name and address, on dedicated shelves labelled with each person's name and address. The pharmacy received copies of hospital discharge summaries via the NHS Discharge Medicines Service. The team checked the discharge summary for changes or new items and liaised with the GP team.

The pharmacy supplied medicine to around 80 people daily as supervised and unsupervised doses. The pharmacy prepared the doses using a pump that was linked to a laptop. The team inputted prescription information into system on the laptop to ensure the pump measured the required doses and printed labels. The pharmacy asked people to present at the pharmacy for their doses between 8.30am and 6.30pm. This gave the team time to set up the pump at the start of the day and to clean and close the pump at the end of the day. The team asked the person to confirm their name, address, date of birth and the dose they were expecting to ensure the correct dose was supplied to the person. The pharmacy

provided a needle exchange service and the sections holding the items to be supplied were organised to enable the team to easily access the items requested by the person. The pharmacy was waiting to receive a bin for people to use when returning containers holding used needles. So, the team signposted people to other healthcare settings that accepted the containers.

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 of completed prescriptions found both boxes were initialled. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy stored incomplete prescriptions in a dedicated area in labelled baskets to ensure when the stock arrived from the wholesaler the team gave priority to the dispensing of these prescriptions. The team had implemented a process for easily locating completed prescriptions and identifying uncollected prescriptions. The pharmacy used an electronic system to record the deliveries due each day. The team added information such as prescriptions that included a fridge item or a CD to prompt the driver to ask for these medicines. The driver used an App on a smart phone to get a signature from the person receiving the medication. The team members had access to the system so they could track the driver doing the deliveries and check the receipt of the medicine when queries arose.

The pharmacy obtained medication from several reputable sources. The pharmacy team regularly checked the expiry dates on stock and kept 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 team members generally recorded the dates of opening on medicines with altered shelf-lives after opening. This meant they 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 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) 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 actioned it and usually kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It makes sure its equipment is used appropriately to protect people's confidential 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 equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the computer near the pharmacy counter in a way to prevent disclosure of confidential information. The pharmacy had cordless telephones to enable the team to hold private conversations with people. The pharmacy stored completed prescriptions away from public view. The pharmacy held private information in the dispensary and rear areas, which had restricted 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.