General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Manor Park Pharmacy, Manor Park Surgery, Bellmount Close, Bramley, LEEDS, LS13 2UP

Pharmacy reference: 1117530

Type of pharmacy: Community

Date of inspection: 09/09/2024

Pharmacy context

This community pharmacy is in the same building as a busy medical centre in a large suburb of Leeds. The pharmacy's main activity is dispensing NHS prescriptions. And supplying several people with their medicines in multi-compartment compliance to help them take their medication correctly. The pharmacy delivers medicines to a few people in their homes. It provides other NHS services including the Pharmacy First 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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows, and it mostly 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 appropriately to errors by discussing what happened and taking action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Most team members had signed the SOPs signature sheets to say they'd read, understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. However, a sample of records showed the last entries were made on 24 July 2024. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing an online report. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening again. The investigation of one dispensing incident revealed it was linked to two medicines that looked alike and sounded alike. And that the pharmacy had been busier than it usually was as there were less team members on duty due to sickness. All team members were made aware of incident at a team meeting and the team's rota was changed. The pharmacists were advised to ensure when working long days to have a mental break from checking prescriptions. And team members were reminded to check the medication selected from the shelves when dispensing a prescription for these medicines. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And it monitored feedback from people left on social media platforms so it could appropriately respond.

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 generally met legal requirements. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. But a sample of RP records showed a few occasions when the pharmacist had not recorded when they had stopped being the RP. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. There was no evidence that the PGDs had been signed by the pharmacists to show they had read them, understood them and would follow them.

Team members completed training about protecting people's private information and they separated confidential waste for shredding offsite. The pharmacy had safeguarding guidance for the team to follow. And team members had completed training relevant to their roles. The pharmacy's delivery driver was experienced and knew the information to be shared with the team when they came across potential safeguarding concerns. In such circumstances the team took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a range of skills and experience 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 have some opportunities to receive feedback and complete ongoing training to further develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and locum pharmacists covered the pharmacy's opening hours. The pharmacy team consisted of four dispensers one who was the pharmacy manager, two regular locum dispensers, a trainee dispenser, a medicines counter assistant (MCA) and a full-time delivery driver. The pharmacy had recently recruited an MCA who was starting the day after the inspection. Occasionally an accuracy checking pharmacy technician worked at the pharmacy to help the pharmacist particularly with the checking of multi-compartment compliance packs.

The team's workload had increased after several people had relocated from other pharmacies in the area. Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They had some specific roles but were all trained on key tasks. This ensured these tasks were completed regularly, including times when team numbers were reduced such as planned and unplanned absence.

The pharmacy occasionally held meetings when the team's workload enabled this. And team members could suggest changes to processes or new ideas of working. This led to changes such as having a dedicated team member responsible for answering the telephone and implementing a team rota. Team members used an online communication platform to share key pieces of non-confidential information with each other, especially if they couldn't attend the team meeting. Additional training provided by the pharmacy for all team members was limited to regulatory training and learning from errors. Some team members independently identified training specific to their learning requirements and completed the training in their own time. Team members received formal and informal performance reviews so they could identify opportunities to develop their knowledge and skills.

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 small, but team members managed the space well and generally worked in a tidy and organised manner. However, several baskets containing completed prescriptions were kept on the floor, which created a trip hazard for team members. The lighting was maintained to appropriate levels and room temperatures were monitored and controlled. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room which team members used for private conversations with people and when providing services. A poster in the area where team members prepared people's supervised doses reminded them to invite the person into the consultation room to take their dose.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. It obtains medicines from reputable sources, and the team adequately stores and carries out checks on medicines to ensure they are in good condition and appropriate to supply. Team members generally manage the pharmacy services safely and effectively to help make sure people receive medicines when they need them. However, the team has not fully assessed the risks associated with providing some medicines outside of the manufacturer's original packaging.

Inspector's evidence

People accessed the pharmacy via two step-free entrances, one from the car park, the other from the medical centre. People could set-up a secure online portal to order their prescriptions and communicate with the pharmacy. Team members took opportunities when speaking to people to promote the portal to help reduce the number of telephone calls received at the pharmacy. Team members asked appropriate questions of people requesting to buy over-the-counter medicines and knew when to refer people to the pharmacist. The Pharmacy First service was promoted within the pharmacy and was popular. Team members were trained on the service so they could assess people presenting at the pharmacy to ensure they met the service criteria before referring them to the pharmacist. A poster displayed by the pharmacy counter detailed information about the service including the medical conditions covered by the service.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. The service was managed by one of the full-time dispensers with support from other dispensers when required. Due to the volume of packs supplied and the pharmacy's limited workspace, the dispensing was divided across four weeks. Prescriptions were ordered two weeks in advance of supply to allow time for issues such as prescription queries to be dealt with. And baskets were used to hold each person's prescription and dispensed medication during the different stages of completing the prescription. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of the packs. A separate section was used to hold packs waiting to be checked so it was clear to the team which packs were ready to be supplied. Completed packs were stored in boxes labelled with the person's name and the day of the week the supply was due. The pharmacy recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. Copies of hospital discharge summaries were sent to the team and checked for changes or new medication. The GP teams used a template to notify the pharmacy of changes to people's medicines that were kept for reference along with notes regarding such changes. Changes to the packs involved a request for another set of prescriptions and the supply of new packs.

The pharmacy supplied medicines to several 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 the correct labels. The team regularly checked and cleaned the pump to ensure the correct doses were measured on each occasion. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP), and they reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. The team reported that no-one prescribed valproate met the criteria. The team was aware of the

requirement to supply original packs of valproate. But reported two people who had their medication in multi-compartment compliance packs also had their prescribed valproate in the packs. The pharmacy had not completed a risk assessment to ensure the supply was issued safely and the two people were aware of the risks associated with valproate medications. This was discussed with the pharmacist manager and dispenser who agreed to complete a risk assessment.

The pharmacy, particularly the dispensary, was small for the volume of prescriptions dispensed. Most dispensing benches were filled with baskets which gave limited free space for team members to work. However, the team organised the dispensary into sections providing separate areas for 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. 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. The pharmacy kept a record of the delivery of medicines to people, so team members had the information available when queries arose.

The pharmacy obtained its medication from recognised sources and generally kept the medicines tidily on the shelves. However, some sections of shelves were cluttered with medicine stock including some loose strips of medication which ran the risk of the team picking the wrong medication when dispensing. Team members checked the expiry dates on stock and marked medicines that were approaching their expiry date. This prompted them to check the medicine was still in date when dispensing. No out-of-date stock was found during the inspection. The dates of opening for medicines with altered shelf-lives after opening were recorded so the team could assess if the medicines were still safe to use. Team members checked fridge temperatures each day but did not keep a record of the readings, so there was no audit trail that the fridges were working correctly. At the time of the inspection the temperatures of all the fridges were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And the team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices via email and the team took appropriate action in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. It had three fridges for storing medicines requiring these temperatures and the team used the fridges in a way to separate medicine stock from completed prescriptions. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used a telephone system with cordless option to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary 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.