General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 540 Broad Lane, Stanningley, PUDSEY, West Yorkshire, LS28 6PA

Pharmacy reference: 1118408

Type of pharmacy: Community

Date of inspection: 31/01/2023

Pharmacy context

This community pharmacy is next door to a medical centre in a suburb of Leeds. The pharmacy provides a range of services including dispensing NHS prescriptions and the NHS hypertension case finding service. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medication. And it delivers medicines to some 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 well. It has up-to-date written procedures that the pharmacy team follows. And it completes the records it needs to by law. Team members suitably protect people's confidential information, and they clearly understand their role to help protect vulnerable people. The team members respond appropriately when mistakes happen, they discuss what happened and take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team members with information to perform tasks supporting the delivery of the pharmacy services. The SOPs were kept electronically which each team member accessed through personal logins. They answered a few questions related to each SOP to demonstrate they'd understood the SOP and would follow it. Team members were advised of new and updated SOPs and could monitor their progress with reading and signing off the SOPs. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions, known as near miss errors. The team member involved was asked to identify their error, correct it and record it on an electronic platform. The pharmacy completed electronic records of errors identified after the person received their medicine, known as dispensing incidents. The pharmacy supervisor regularly reviewed the near miss errors and dispensing incidents. And shared the outcome from the review with team members, who discussed the changes they could make to prevent future errors. Examples of changes made following recent reviews included the pharmacist completing the accuracy check on certain prescriptions rather than the accuracy checking technician and supervisor. And separating medicines that looked alike and sounded alike. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A leaflet provided people with information on how to raise a concern with the pharmacy team.

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 RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The CD registers were kept electronically, and the system captured the current stock balance for each CD register which was checked against the physical stock, on the same day each week. This helped to identify issues such as missed entries. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a separate privacy notice. The team members completed training about the General Data Protection Regulations (GDPR). And they separated confidential waste in a marked container before transferring it to a bin for shredding offsite.

The pharmacy had safeguarding procedures for the team members to follow, and they had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Team members responded well when they identified safeguarding concerns. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP. The team members providing medicines in multi-compartment compliance packs monitored people's use of

them. And when concerns arose, they liaised with the GP team to agree alternate support such as moving the person from monthly to weekly supplies.

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. The team members work very well together, and they are good at supporting each other in their day-to-day work. The pharmacy provides team members with ongoing training. They benefit from identifying areas of their own practice they wish to develop and are supported to acquire new skills.

Inspector's evidence

A full-time pharmacist manager covered most of the opening hours with locum pharmacist support. The pharmacy team consisted of a full-time trainee pharmacist, a part-time accuracy checking technician (ACT) who was also the pharmacy supervisor, a part-time accuracy checking dispensing assistant (ACDA) and seven part-time dispensers.

The team members worked very well together and supported each other particularly when people presented at the pharmacy counter to ensure they were not kept waiting. The ACT and ACDA supported the pharmacist by completing the accuracy checks of repeat prescriptions and prescriptions for medicines in multi-compartment compliance packs. All team members were trained on how to undertake key tasks and a team rota ensured these tasks were completed each day. The rota was also used to support the team at times when team numbers were reduced such as unplanned absence. Team members moved between their allocated daily tasks when workload changed so they could support colleagues.

The trainee pharmacist received support from the pharmacist who was their supervisor and the rest of the team. This included asking the trainee to speak to people requesting an over-the-counter medicine or advice about a medical condition. The trainee was invited to analyse the near miss errors and dispensing incidents and produced a set of slides of their findings to present to the team. One outcome from the analysis was to advise the team of the importance of accurately recording dispensing incidents.

The pharmacy provided team members with additional training on a range of subjects. And it provided team members with formal performance reviews and informal feedback, so they had opportunities to develop their skills and take on more roles. The ACDA had been encouraged to take on this role and was supported by the pharmacist manager throughout their training and on a continual basis. The pharmacy frequently held team meetings and team members held short meetings during the day if an urgent issue arose. Team members not on duty at the time were updated.

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 its services.

Inspector's evidence

The pharmacy premises were hygienic with separate sinks in place for the preparation of medicines and hand washing. Hand sanitising gel was available in several areas of the pharmacy for the team and people to use. Team members wore disposable gloves when dispensing medication into multi-compartment compliance packs. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter.

The team kept floor spaces clear to reduce the risk of trip hazards. And there was enough storage space for stock, assembled medicines and medical devices. The dispensary was large with plenty of bench space for the team members to work from. There was a defined professional area and items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room that the team used for private conversations with people and when providing pharmacy services. The pharmacy had restricted public access to the dispensary during the opening hours.

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. Team members manage the pharmacy services well to make sure people receive their medicines when they need them. They store medicines properly and they regularly check to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and there was plenty of room for people to easily move around the retail area. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team provided people with information on how to access other healthcare services when required. Team members wore name badges so people knew who they were speaking to. They asked appropriate questions when selling over-the-counter products and they knew when to refer to the pharmacist. People were given clear advice on how to use their medicines. And the team used alert cards for higher-risk medicines to prompt the pharmacist to ask for information from the person such as their latest blood test results to ensure supplies were appropriate. However, the person's electronic medication record was not always updated following such conversations with the pharmacist. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And they regularly reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. The pharmacy provided services such as emergency hormonal contraception against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to supply the medicine. The team worked closely with the team at the nearby medical centre which was helpful during recent issues with the availability of antibiotics. Regular communications between both teams had provided updates on the antibiotics that were available and when to use the national serious shortage protocol (SSP).

The pharmacy sent several prescriptions to the Well offsite dispensary hub. The team processed the prescriptions, and the pharmacist completed a clinical check of the prescriptions before the prescription data was sent to the hub for dispensing. Some medicines such as controlled drugs and items the person urgently needed were dispensed at the pharmacy to reduce risk and ensure people's medicines were ready when they needed them. The dispensed prescriptions were generally returned to the pharmacy the following day when the prescription data was sent before midday. They were supplied in a sealed bag with an embedded bar code, which the team scanned to confirm receipt. The team members stored the completed prescriptions from the offsite hub separately to medicines dispensed at the pharmacy. And they used the bar code scanning to identify where all the completed prescriptions for a person were held to ensure all their medicines were handed over.

The pharmacy provided multi-compartment compliance packs to help around 280 people take their medicines. The pharmacy had increased the number of people it provided the service to as other pharmacies in the area no longer offered the service. The ACT and a full-time dispenser managed this service with support from other team members. They mostly worked from a large room to the rear of the pharmacy that was away from the distractions of the main dispensary and retail area. To manage the workload they divided the preparation of the packs across the month with each week colour coded to improve the efficiency of the process. And they generally ordered the prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing

their current medication and dose times which the team referred to when checking the received prescriptions to identify any changes or missing items. They also referred to the list throughout the dispensing and checking of the packs. When a new medicine was prescribed with an unclear dose time the dispenser checked with the pharmacist and ACT before updating the medicine list. And they confirmed any changes to a person's medication with the GP before amending the list. The pharmacy occasionally received copies of hospital discharge summaries which were checked for changes or new items. The team recorded the descriptions of the medicines 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 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 they were securely stored and separately, with the prescription attached.

The large dispensary provided plenty of space for the team to separate the 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 the dispensing labels. These recorded who in the team had dispensed and checked the prescription and a sample found that the team completed both boxes. The pharmacist recorded when they'd completed the clinical check of the prescription to enable the ACT and ACDA to undertake the accuracy check. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines to allow the team, and the person collecting the medication, to check the supply. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were made within the 28-day legal limit. The pharmacy's IT system enabled the team members to track the progression of the dispensing of prescriptions. So, they could advise people presenting for their prescription. They stored completed prescriptions neatly on dedicated shelves. And scanned the prescriptions into a particular area on the shelves using a barcode attached to the shelf. When the person came to collect their prescription, the team used the barcode scanning to identify where the prescription was held and to check the correct prescription had been picked. The pharmacy sent people a text message to advise them when their prescription was ready to collect. And it kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from reputable sources and team members followed procedures to ensure the medicines were safe to supply. This included regular checks of the expiry dates on stock and marking medicines with a short expiry date to prompt them to check the medicine was still in date. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and 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 printed off the alert, actioned it and kept a record.

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 resources and access to the internet to provide the team with up-to-date clinical information. It had a range of equipment available for the services provided including CE equipment to accurately measure liquid medication and a separate, marked counting triangle for cytotoxic medicines. There was also a blood pressure monitor that was regularly checked to ensure it gave accurate readings. The pharmacy computers were password protected and access to people's medication records restricted by the NHS smart card system. The pharmacy stored completed prescriptions away from public view and it held private 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.