General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oakwood Lane Pharmacy, Amberton Terrace, LEEDS, LS8 3EZ

Pharmacy reference: 1125165

Type of pharmacy: Community

Date of inspection: 14/01/2020

Pharmacy context

This community pharmacy is within a large GP surgery in the Leeds suburb of Oakwood. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides a supervised methadone consumption service. And a needle exchange service.

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	1.2	Good practice	The pharmacy team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
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 team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. And team members respond to this feedback to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has arrangements to protect people's private information. And it keeps most of the records it needs to by law.

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. Each team member had a signature sheet stating their role in the pharmacy and listing the SOPs relevant to their role. The team members had signed the SOP signature sheets to show they understood and would follow the SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. And each team member recorded their own error. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. And team members usually recorded why the error happened and what they would do to prevent the error happening again. Examples of the cause of the error included the team member not checking the size of the box. Examples of the actions taken included the team member to take their time when dispensing. And to carefully read the prescription. The pharmacy team recorded dispensing incidents electronically. The team discussed a recent dispensing incident involving the supply of the wrong strength of a product to a person. The team identified a cause of the error was the similar packaging for the different strengths of the medicine. The team members were reminded to check the strengths selected. And the pharmacy was attempting get the strengths from alternate suppliers. So, the packaging would look different. The team identified medicines often involved with errors due to them looking and sounding alike (LASA). And the team members attached LASA stickers to the shelves holding these medicines to prompt the them to check the medicine they had picked.

The pharmacist and pharmacy pre-registration student reviewed the near miss errors and dispensing incidents to spot patterns and make changes to processes. The details from the review were recorded on the back of each near miss log. And shared with the team. A recent review highlighted errors with the wrong formulation of CDs. The team members were reminded to get a second check of the CD dispensed before passing it to the pharmacist to do the final check. And to highlight CD prescriptions and put them in a dedicated basket for entering in to the CD register. So, any discrepancies could be promptly identified, corrected and reported.

The pharmacy had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the retail area. People completing the survey commented that the

pharmacy team was polite and helpful. Some people completing the survey had commented on the lack of advice on physical exercise. The team used the notice board in the retail area to display information on physical exercise from organisations such as We Are Undefeatable.

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 met legal requirements. Records of emergency supply requests met legal requirements. A sample of records of private prescription supplies looked at found that the prescriber's details were incorrect or 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 training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level two training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Some team members had completed Dementia Friends training. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The team members support each other in their day-to-day work. And they discuss their mistakes and how they can prevent them from happening again. So, they can improve their performance and skills.

Inspector's evidence

The pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pre-registration pharmacy student, three full-time qualified dispensers, a part-time medicines counter assistant (MCA) and a part-time delivery driver. At the time of the inspection the pharmacist manager, the pre-registration student, one of the dispensers and the MCA were on duty. The pharmacist manager worked with the team to ensure each team member was not doing one task all day. This ensured the team members kept their focus on the tasks. And ensured they had a range of skills, so they could support the pharmacy services in times of absence.

The pharmacist manager was the tutor for the pharmacy pre-registration student. The two had discussed the year ahead based on the structured programme and the personal objectives of the student. The student worked at the pharmacy before starting their University course. So, had experience of the pharmacy services offered and knew the layout of the pharmacy. The student wanted to focus on developing their skills and knowledge of selling over-the-counter medicines. And counselling people and giving advice on health matters. The team supported the student by referring queries from people to the student. And providing the student with information about medicines and answering their questions.

The pharmacy provided extra training through materials from external organisations such as CPPE. The team members had protected time to complete the training. The pharmacy held monthly team meetings and it provided performance reviews for the team members. So, they had a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The pre-registration student identified the issue of waste when the wrong strength of antibiotic liquid was prepared. So, advised team members to double check the strength selected before preparing the liquid. The pharmacy did not set targets for services. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The team 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 large, sound proof consultation room. The team used this for private conversations with people.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. And it manages its services well. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately. The pharmacy has adequate procedures to manage its services. It keeps records of prescription requests. So, it can deal with any queries effectively. But the delivery driver doesn't always obtain signatures from people for the receipt of their medicines. So, the pharmacy doesn't have a robust audit trail and cannot evidence the safe delivery of people's medicines.

Inspector's evidence

People accessed the pharmacy via the surgery and from the main road through an automatic door. 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-compartment compliance packs to help around 29 people take their medicines. The team members identified they had reached a maximum number of people to provide this service to. So, to take on more people could risk the safe delivery of the service. The team explained this to people and GPs teams asking about the service. The pharmacist manager was working with the GP teams to assess people's needs and the support they required for taking their medicines. People received monthly or weekly supplies depending on their needs. One of the qualified dispensers managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team used a spreadsheet to track the different stages of preparing the packs. The information on the spreadsheet included the dates for ordering the prescriptions and when the supply was due. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. 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 used the medication list to capture information about the medicines in the packs. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer's patient information leaflets. The pharmacy occasionally received copies of hospital discharge summaries. Usually the team received this information from the person or the GP team. The team checked the discharge summary for changes or new items.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet. All the doses were stored in the same basket. There was no separation of individual doses to help reduce the risk of selecting the wrong one. The pharmacist spent time with people asking how they were feeling. And referred people who needed support with health issues such as alcohol dependence to the nurses at the health centre. The needle exchange service involved people placing the used needle containers directly into a dedicated waste bin. So, the team had no direct contact with the containers.

The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions a few days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of the request on the computer. And regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The team

passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy displayed a poster in the dispensary providing the team with information about PPP. The pharmacy completed audits of people on high-risk medicines. The pharmacy pre-registration student led on this. Recent audits included checking that people prescribed anti-inflammatory medicines were also prescribed medication to protect their stomach. The team marked prescriptions to indicate an anti-inflammatory medicine was included. The pharmacy kept records of the checks the pharmacist did when a prescription for a medicine prescribed outside of the manufacturers' licence was presented. So, the team could refer to the information if queries arose.

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 team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The team used dedicated shelves to store baskets holding prescriptions awaiting checking. 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 had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. 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 completed the boxes. When the pharmacy didn’t have enough stock of someone’s medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. One team member checked the owing prescriptions each day to ensure the medicine had been ordered. So, people were not kept waiting for their medicines. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. But this was only for CD deliveries. So, the pharmacy didn’t have a full audit trail or proof of delivery for all prescriptions.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 09 January 2020. The team used coloured dots to highlight medicines with a short expiry date. No out of date stock was found. 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. For example, an opened bottle of Oramorph oral solution with 90 days use once opened had a date of opening of 19 December 2019 recorded. The team recorded fridge temperatures each day. A sample looked at 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 had equipment and a computer software upgrade to meet the requirements of the Falsified Medicines Directive (FMD). But the team was not scanning the FMD products. 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, actioned it and kept a record.

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 references 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. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. And the team used a Microlife BP monitor when taking people's blood pressure readings.

The computers were password protected and access to people's 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 and rear areas, 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.