General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Brooklands Pharmacy, 21 Sticker Lane, BRADFORD, West Yorkshire, BD4 8DP

Pharmacy reference: 1126487

Type of pharmacy: Internet / distance selling

Date of inspection: 05/12/2019

Pharmacy context

This pharmacy provides pharmacy services at a distance. People can access the pharmacy website and contact the pharmacy by telephone. It dispenses NHS prescriptions and supplies multi-compartment compliance packs to help people take their medication. The pharmacy requests prescriptions on behalf of people. And it delivers people's medicines to their homes.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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 generally identifies and manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures. And it has adequate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't fully record the errors or review them. This means the team does not have information to help identify patterns and reduce mistakes. The pharmacy team has some training to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. But the pharmacist has not completed any safeguarding training specific to their role.

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. All the team including the delivery driver had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. 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. A sample of the near miss error records looked at found that the team recorded the type of error such as incorrect quantity. But the details of what had been prescribed and dispensed were not recorded to help spot patterns. The team members recorded the actions they had taken to prevent the error happening again. But they did not record what caused the error. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. Following a delivery error when one family member received another family member's medication. The team identified that the person had asked for the delivery to be to another address. But the person had not confirmed this with the people at the other address. After this the team agreed to only deliver to the address on the prescription. And to arrange with the person the time they would like a delivery. The delivery driver worked full-time so the team was able to offer time slots across the working day. The pharmacy did not review the error records to identify patterns. And to act to prevent common errors from happening again.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And the pharmacy website provided people with information on how to raise a concern. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. 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 website displayed details of the 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 not completed level two training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. And the team members, including the delivery driver, knew the issues to look out for that may indicate a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to provide the pharmacy's services. And they support each other in their day-to-day work. The team members discuss and share ideas. They identify improvements to the delivery of pharmacy services. And they update their processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A regular locum pharmacist covered most of the opening hours. Other locum pharmacists provided support when required. The pharmacy team consisted of a full-time trainee pharmacy technician who was also the pharmacy manager, one part-time dispenser, a full-time pharmacy apprentice and a full-time delivery driver. At the time of the inspection the regular locum pharmacist, the trainee pharmacy technician, the dispenser and the pharmacy apprentice were on duty. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The pharmacy did not provide protected training time for the trainee pharmacy technician. So, the trainee pharmacy technician used their lunch breaks and time at home for study. The pharmacy held morning team meetings to plan the day ahead. The pharmacy manager had also introduced a Friday team meeting. This gave the team a chance to reflect on what they had achieved during the week, what had gone well and to make plans for the following week. The team had worked together to get ahead with the preparation of the multi-compartment compliance packs.

Team members could suggest changes to processes or new ideas of working. The team identified that all team members should be trained in the key tasks. So, they could update their skills and help with the delivery of services in times of absence. This was implemented and team members rotated the tasks amongst themselves during the day. So, they could remain focused and ensure the tasks were completed. One of the team had introduced a notice board for the team to record information for everyone to refer to. This was particularly helpful for team members who worked part-time. So, they could pass on information and know what happened when they were not on duty. The pharmacy did not set targets for the pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided.

Inspector's evidence

The premises were secure. The pharmacy had restricted access during the opening hours. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And the pharmacy team used disposable gloves when dispensing medicines in to the multi-compartment compliance packs. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. 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 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. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medication appropriately. Team members don't always check and record fridge temperatures. So, there is a risk if the fridge stops working, they may supply medicines that are not fit for purpose.

Inspector's evidence

The pharmacy was closed to the public which meant that people could not access the premises directly. People could access the pharmacy website and the contact details were on the dispensing labels for people to ring the team. The pharmacy sold a small range of over-the-counter medicines. These were not sold through the website, but people asked for them when their prescription medicines were delivered. The pharmacist spoke to people requesting over-the-counter medicines. And the team recorded the sale.

The pharmacy provided a repeat prescription ordering service. The team members had a system to remind them when they had to request the prescription. The team rang the person to ask what medicines they needed. When the person did not order a medicine that should be regularly taken the team discussed this with the person. And when necessary contacted the person's GP or the pharmacist at the GP surgery. So, they could speak to the person to find out why they were not taking their medicines. The team kept records of the requests to identify missing prescriptions and chase them up with the GP teams. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And stated they did not have anyone prescribed valproate that met the criteria. The team was not sure if the pharmacy had received the PPP pack containing information to give to people prescribed this medicine. But the team members could access the internet to get this information if needed. The pharmacy team did not always ask people prescribed high risk medicines such as warfarin if they knew when they had their last blood test or what dose they were taking.

The pharmacy provided multi-compartment compliance packs to help around 73 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team was working to get ahead for the busy Christmas period. The team usually ordered prescriptions two weeks before supply. This allowed 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 GP team released the prescriptions each week. To manage the workload and to reduce the risks of errors when dispensing and checking the packs close to the time of supply the team prepared four weeks packs together against the first prescription and the medication list. The packs were stored on dedicated shelves awaiting the prescription. The pharmacist

checked all the packs using the first prescription and medication list. And then the pharmacist checked the packs again each week when the prescription arrived at the pharmacy. The team picked the medicines before dispensing and ordered missing stock. So, the team member dispensing the packs had all the medicines available. The team members placed the medication list on a stand in front of them when dispensing the medicines in to the packs. So, they could refer to this throughout the dispensing of the packs especially the time slots the medicines were placed in to. The team recorded the descriptions of the products within the packs. But it did not always supply the manufacturer's patient information leaflets. The team stored completed packs on dedicated shelves labelled with the person's name and address. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items.

The pharmacy provided some separation for 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 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 usually 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. The pharmacy kept a record of the delivery of medicines to people. And the record had a section to capture the signature from the person receiving the medication. But a sample of delivery records looked at found there were no signatures. So, there was no evidence of the supply if the person contacted the pharmacy asking for their medicines.

A box of MST 10mg tablets was found that contained strips of medicines from different manufacturers. So, the team may not know if the contents of the box were the same as the batch number and expiry date on the packet if a safety alert came through. No other boxes were found with different manufacturers strips inside. The pharmacy team checked the expiry dates on stock. The team kept a record of this, but it was not available at the time of the inspection to see when the last date check took place. The team marked 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. The pharmacy had a template for the team to record fridge temperatures twice a day. A sample looked at found no records had been made in December 2019. The fridge temperature on the day of the inspection was within range. The team had recorded the fridge temperatures in other months. 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 no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team did not know when the pharmacy would be FMD compliant. 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 but didn't keep a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to 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 a fridge to store medicines kept at these temperatures. The computers were password protected and access to people’s records restricted by the NHS smart card system.

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.