General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Care Meds UK, Lancaster House, Lancaster Road, Carnaby, Bridlington, East Riding of Yorkshire, YO15 3QY

Pharmacy reference: 9010098

Type of pharmacy: Closed

Date of inspection: 25/10/2022

Pharmacy context

This pharmacy provides its services at a distance and access to the premises is closed to the public. People can visit the pharmacy website and contact the pharmacy by telephone. The pharmacy's main activities are dispensing NHS prescriptions and delivering medicines to people's homes and to care homes over a large geographical area. The pharmacy supplies medicines in multi-compartment compliance packs to help people take their medication.

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	2.5	Good practice	The pharmacy encourages the team members to share ideas on how to improve the delivery of services through regular meetings. And they actively engage in providing feedback on any changes that may affect their ways of working.
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. It mostly completes the records it needs to by law and it suitably protects people's private information. The pharmacy provides its team members with training and guidance to help them respond to safeguarding concerns. They act appropriately when mistakes happen. But they don't complete full records to help prevent future mistakes and improve the safety of services.

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 team 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 pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. On most occasions the pharmacist or accuracy checking technician asked the team member involved to find and correct their error. The pharmacy had a template to capture these errors and team members generally recorded their errors. The records that were completed had sufficient details including the team member's learning from the error and the action they'd taken to prevent the error happening again. The pharmacy had a separate procedure for managing errors identified after the person had received their medicine, known as dispensing incidents. These were recorded and shared amongst the team members so they were all aware. The pharmacy occasionally reviewed the errors and dispensing incidents to look for trends, however the last review was in March 2022. The outcome from this review was discussed with the team members who were reminded to use equipment such as counting triangles to ensure the correct quantity was dispensed. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the pharmacy website had information providing people with information on how to raise a concern with the team.

The pharmacy had up-to-date indemnity insurance. Records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. A sample of RP records found a few missing entries. The pharmacist checked the balance of most of the CD registers to identify issues such as missed entries. The pharmacy received CDs back from the care homes for destruction. The SI reported the care home teams didn't always inform the pharmacy that CDs were being returned. And this sometimes impacted on the team's workload as the CDs had to be recorded and appropriately destroyed. The SI discussed asking the care home teams to give advance notice and to scan and email the pharmacy a list of the CDs being returned. So, the pharmacy team was aware and could prepare. The pharmacy had procedures and training for the team to follow to ensure people's private information was securely managed. The pharmacy's website displayed information on the confidential information it kept and how it complied with the relevant legislation. The team members had a good understanding of how to protect people's confidential information and they separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures, training and guidance for the team to follow. The SI had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting

children and vulnerable adults. The SI was asked for their support and advice from the care home teams when a safeguarding matter was raised.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a 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 share ideas on how to improve the delivery of services through regular meetings. And they actively engage in providing feedback on any changes that may affect their ways of working. The team members benefit from identifying areas of their own practice they wish to develop, and the pharmacy helps them to achieve this.

Inspector's evidence

The Superintendent Pharmacist (SI) and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time accuracy checking technician (ACT) who was the pharmacy manager, another full-time ACT, eleven qualified dispensers, four trainee dispensers and four delivery drivers. The qualified dispensers and trainee dispensers worked full and part-time hours.

The pharmacy had a team rota to ensure all key tasks were completed and there was no impact on pharmacy services at times of unplanned absence. The team members were trained on the keys tasks to ensure they had the appropriate skills to complete the tasks. The trainee dispensers received support from experienced colleagues who they could ask questions of. One of the experienced dispensers was observed providing a clear explanation to a trainee dispenser on how to complete a particular task. One of the trainee dispensers was responsible for answering the telephone and clearly knew who in the team to refer queries to that she couldn’t answer.

The team regularly met to discuss the pharmacy services and suggest changes to processes if needed. One team member had suggested a change to the process of putting medicine stock away after it was delivered from the wholesaler. The suggestion was made after a new delivery time was introduced that had an impact on the team’s workload. The task had been included in the daily rota of tasks so a team member focused on checking the medicines and putting them away. The team members had identified that several care home teams didn’t always follow the procedures for ordering monthly prescriptions. So, they spent time with each care home team explaining the process and providing information on how to complete the prescription ordering process. This approach resulted in prescriptions arriving at the pharmacy in plenty of time to be dispensed and supplied. The pharmacy manager regularly met with the regional manager of the company that owned the care homes and contacted them when issues or concerns arose.

The pharmacy provided team members with formal performance reviews and informal feedback. Recent reviews included team members requesting more training and experience with the processing of the documents that accompanied the medication sent to care homes. The pharmacy encouraged and supported the team to develop their skills and knowledge. The ACT pharmacy manager had started as a trainee dispenser before progressing to be an ACT. And had recently enrolled onto an NVQ4 qualification programme. The pharmacy provided the team members with some additional training to their formal qualifications. This included training on the General Data Protection Regulations.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic, and secure.

Inspector's evidence

The pharmacy was tidy and hygienic. It provided separate sinks for the preparation of medicines and hand washing. It had sufficient space for dispensing activities and enough storage space for stock, assembled medicines and medical devices. The team kept the floor spaces clear to reduce the risk of trip hazards. The pharmacy had restricted public access to the dispensary during its opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. It keeps detailed records to help monitor the services it provides and to enable the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

The pharmacy was closed to the public which meant people could not directly enter the pharmacy. The pharmacy website provided people with information on the services offered, the contact details of the pharmacy and the opening hours.

The pharmacy supplied medicines to approximately 30 care homes across a large geographical area. Most of the medicines were supplied in multi-compartment compliance packs. To manage the workload the team divided the processing of the prescriptions across the month. The team prompted care home teams to order the prescriptions in good time. And it received up-to-date information on people's current treatment and medication needs for that month. The team used this information when checking the prescriptions and before sending the care home teams copies of the prescriptions. So, the care home teams could check that all the medicines they'd ordered had been prescribed. The pharmacy asked the care homes teams to manage queries or missing medicines before an agreed day in the cycle to enable the team to complete the dispensing of the prescriptions. The team sent a medicines list and administration chart for each person in the care home with the person's medication. This included a photograph of the person and photographic images of the medicines. And it supplied the manufacturer's packaging information leaflets so the care home team could identify the medicines in the packs and had information about people's medication. The pharmacy sent the medication to the care home several days before the next cycle. This enabled the care home teams to check the supply and chase-up any missing items. Occasionally the pharmacy received copies of hospital discharge summaries which the team members checked for changes to treatment. And they liaised with the care home teams when changes occurred to make sure people took the right medicines.

The pharmacist completed a clinical check to enable the ACTs to undertake their accuracy checks. The ACTs checked most prescriptions except ones with CDs and acute prescriptions for medicines such as antibiotics. The team used a separate part of the dispensary to dispense acute prescriptions. And a dispenser was allocated from the team rota to complete these prescriptions.

The SI and pharmacy manager regularly contacted the care home teams to answer any queries or concerns. And the SI spoke to the care home team when new medicines were prescribed. For example, when a new medicine had particular dose instructions. During the dispensing process, the team highlighted new medicines on the prescription token together with any interactions so the pharmacist and ACTs were aware. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided to people. The pharmacy didn't have anyone prescribed valproate who met the PPP criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Different

team members were involved in the various stages of dispensing the prescriptions. This included labelling the prescription and picking the medicines. The team members used baskets during the dispensing process to isolate individual people's medicines, the prescription and the person's medicine list. And they used different coloured baskets for each care home. The pharmacy had checked by and dispensed by boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. A sample found that the team completed both boxes. The pharmacy had a detailed process for preparing prescriptions for delivery that a team member was allocated to complete each day. This involved matching all the dispensed medicines against the medication order list and completing a check of relevant paperwork such as the medicines administration record. The bagged medication was then placed into a dedicated delivery area for the driver to collect. The pharmacy kept a record of the delivery of medicines.

The pharmacy obtained medication from several reputable sources. The team had regular conversations with the wholesalers regarding quotas on certain medicines that the pharmacy used more than other pharmacies. This helped to ensure there was enough medicine stock to supply to the care homes. The pharmacy team checked the expiry dates on stock and usually kept a record of this, however the last record was made in March 2022. 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 recorded the dates of opening for medicines with altered shelf-lives after opening so 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 the temperatures 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 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 usually 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. 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 clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication and a fridge to store medicines kept at these temperatures. The fridge had a glass door that enabled the team to check the stock without prolong opening of the door. The computers were password protected and access to people's records was 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.