General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wakefield Pharmacy, 4a The Gateway, Fryers Way, Ossett, West Yorkshire, WF5 9TJ

Pharmacy reference: 9010606

Type of pharmacy: Internet / distance selling

Date of inspection: 01/07/2021

Pharmacy context

This pharmacy is a distant selling pharmacy and access to the premises is closed to the public. People can access 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. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy was inspected during the COVID-19 pandemic.

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 generally identifies and manages the risks associated with its services including the risks from COVID-19. It has written procedures that the pharmacy team follows. And it mostly completes all the records it needs to by law. The pharmacy team members respond appropriately when errors occur. They discuss what happened and they take suitable action to prevent future mistakes. When people report that the pharmacy's services are not to the required standard the team members listen and they make changes to the way they work.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had assessed the risk for all team members of catching the virus. And it had taken appropriate action to reduce the risk. In addition to the team members only the delivery drivers from the wholesalers entered the pharmacy. This meant contact with people other than colleagues from the team was kept to a minimum. The pharmacy consisted of a large room which provided plenty of space for the team members to support social distancing requirements and to manage infection control. The team members wore Personal Protective Equipment (PPE) masks. And hand sanitising gel was available for the team to use.

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs were due to be reviewed in May 2021 but the review had not been completed. 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. They referred queries from people to the pharmacist when necessary.

The pharmacy kept records of errors identified by the pharmacist when checking dispensed prescriptions. The details on the records enabled the team to identify patterns. The records captured the cause of the error and the action taken to prevent the error happening again. The pharmacy had an electronic reporting template to capture errors that reached the person, known as dispensing incidents. The team had investigated the cause of a dispensing incident when medication supplied in a compliance pack was in the wrong time slot. This revealed the medication had moved when the pharmacist was sealing the pack after completing the final check. To prevent this from happening again the team ensured the packs were sealed after all the medicines were dispensed into the packs, before the pharmacist checked the pack. The pharmacy website provided people with details on how to raise a concern. The pharmacy supervisor captured feedback from people using the pharmacy services on a notice board for all team members to see. The information included people who had raised concerns about delays with receipt of their medication. And information from the team at the medical centre about a person who demonstrated aggressive behaviour. This meant the team members could respond appropriately when the person contacted the pharmacy.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers mostly met legal requirements. On a few occasions the RP record didn't capture when the RP had signed out. The pharmacy website provided people with its privacy policy and the team separated confidential waste for shredding offsite. The pharmacy had received concerns from some people about the security of their personal data when

providing bank details for payments. The team provided a password to the team at the medical centre who passed it on to the person. When the person was contacted by the pharmacy team, they asked the team member for the password to authenticate the call before providing their payment.

The pharmacy team members 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. The team members were aware of the Ask for ANI (action needed immediately) initiative. The team responded well when safeguarding concerns arose. The delivery drivers reported concerns about people they delivered medication to back to the team who took appropriate action. This included contacting the person's carers.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They discuss and share ideas and they actively identify improvements to the delivery of pharmacy services. Pharmacy team members receive feedback on their performance and they have some opportunities to complete ongoing training.

Inspector's evidence

The Superintendent Pharmacist covered most of the opening hours and had regular locum pharmacist support when required. The pharmacy team consisted of a full-time dispenser who was also the pharmacy supervisor, a part-time dispenser, two full-time pharmacy apprentices and five part-time delivery drivers. At the time of the inspection a locum pharmacist, the pharmacy supervisor, the dispenser and the two pharmacy apprentices were on duty. The pharmacy apprentices received support from the experienced team members and as their training progressed were given additional responsibilities.

The supervisor had been in position for six months and received support from the pharmacy owners to develop the role. The supervisor developed a rota of daily tasks for the team members to complete. This meant they all could complete these tasks confidently and completion of these tasks was not affected by team absence. The team members had access to online training modules to keep their knowledge up to date. And they had protected time to complete the training. The pharmacy provided regular performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the delivery drivers had asked to be more professional in their appearance. In response the pharmacy ordered shirts with the pharmacy named embossed for the drivers to wear. The pharmacy had also bought new delivery vans with air-conditioning installed.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And the team kept floor spaces clear to reduce the risk of trip hazards. The premises were secure and had restricted access during the opening hours. The pharmacy did not have any signs on the outside of the building to show it was a pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are well-managed so people receive appropriate care. The pharmacy keeps detailed records to help monitor the services it provides. This enables the team to deal with queries effectively. And it makes sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores and manages its medicines and appliances correctly.

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 about the services offered such as the delivery service, the operating hours and contact details for the pharmacy. The pharmacy had two telephone lines which enabled people to easily contact the team. When the pharmacy was closed people could leave a voicemail message which the team responded to when the pharmacy re-opened. The team provided people with clear advice on how to use their medicines. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and had PPP information to provide people with when required. The team used the electronic patient record (PMR) to capture information about people and their medication.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. And used a dedicated area of the pharmacy to prepare the packs. The team usually ordered prescriptions a week before supply to allow time to deal with issues such as missing items and the dispensing of the medication into 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 kept a record of who had been involved in the different stages of preparing the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s information leaflets. This meant people could identify the medicines in the packs and had information about their medication. The pharmacy sometimes received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. Information received about a person’s medication was captured on a dedicated sheet kept with the medication list so all the team members were aware.

The pharmacy provided medicines in multi-compartment compliance packs to seven care homes. The care home teams ordered the prescriptions and sent the pharmacy details of the medicines requested. This meant the pharmacy team had information to know if any items were missing from the prescriptions received at the pharmacy. The pharmacy supplied the medicines to the care homes seven days before the start of the next monthly cycle. This gave the care home teams time to check the supply and chase-up any missing medication.

The pharmacy provided separate areas for labelling, 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 dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample of dispensed medicines found that the team completed the boxes. When the pharmacy didn’t have enough stock of someone’s medicine, the team contacted the person to let them know. And provided a printed slip

detailing the owed item. Throughout the pandemic the pharmacy had seen an increase in requests for the delivery service. The team of delivery drivers provided the service morning and afternoon with some late evening deliveries made to the care homes. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to the COVID-19 pandemic the delivery driver did not ask people to sign for receipt of their medication. The pharmacy used Royal Mail when supplying medicines to people who lived a distance from the pharmacy. The team kept a separate record of these deliveries and informed the person of the expected date of delivery.

The pharmacy obtained its medicines from several reputable sources The pharmacy team checked the expiry dates on stock and kept a record of this. 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 dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team 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 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 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 safe services and it uses its facilities to suitably 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 had equipment available for the services provided. The equipment included a range of CE equipment to accurately measure liquid medication. The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. The pharmacy stored completed prescriptions away from public view.

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.