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: 08/03/2023

Pharmacy context

This pharmacy is in Ossett, in West Yorkshire. People access services through its website and they contact the team by telephone. The premises are closed to the public. The pharmacy's main activities are dispensing NHS prescriptions and delivering medicines to people's homes. The pharmacy supplies medicines in multi-compartment compliance packs to help some 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	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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows and it mostly completes all the records it needs to by law. The team protects people's private information correctly. Team members respond appropriately when errors occur. They discuss what happened and they take action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided team members with information to perform tasks supporting the delivery of services. The team had read the SOPs and 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, known as near miss errors. The team member involved was asked to identify the error and correct it so they had an opportunity to reflect on why it happened. A record of near misses was kept and a sample found the details captured enabled the team to identify patterns. There was an electronic reporting template to capture errors that were identified after the person received their medication, known as dispensing incidents. All team members were informed of a dispensing incident and the details were recorded on the person's electronic record kept at the pharmacy. Team members reviewed the near miss errors to identify patterns and to prevent them from happening again. Examples of action taken, included completing a second check of the dosage instructions printed on the label before handing it to the pharmacist to check. And separating medicines that looked and sounded alike. 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 pharmacy had current indemnity insurance and 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 had not been completed. The RP notice was not on show at the start of the inspection but was displayed after this was highlighted. A record of CDs returned to the pharmacy for destruction was kept. This included a record of when CDs were destroyed and details of who had destroyed and who had witnessed the destruction. The pharmacy website provided people with access to its privacy policy and the team separated confidential waste for shredding offsite.

Team members had access to safeguarding information and the pharmacist had completed training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The delivery driver reported any concerns about the people they delivered to, and the team took appropriate action such as contacting the person's GP and carer.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a fairly small team who have an appropriate 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 report any concerns to help ensure the safe and effective delivery of pharmacy services. However, they have limited opportunities to complete ongoing training and reflect on their personal development. So, they may miss the chance to further their skills and knowledge.

Inspector's evidence

The Superintendent Pharmacist (SI) and regular locum pharmacists covered the pharmacy's opening hours. The pharmacy team consisted of a full-time dispenser who was also the pharmacy supervisor, one part-time dispenser, a full-time pharmacy apprentice and a part-time delivery driver. At the time of the inspection the SI and the supervisor were on duty and worked well together. The team had a rota of daily tasks for the team members to complete. This meant they were confident to finish a range of tasks and completion was not affected by team absence.

The pharmacy apprentice had protected time at work to complete their training and was supported by the other team members. There was limited access to additional training for team members to keep their knowledge up to date. They focused on key training such as data protection and information on new medicines. Team members received informal feedback on their performance. But they didn't have the opportunity to formally reflect on their performance in appraisals and may miss opportunities to progress and develop their skills.

Team members regularly held meetings where they planned their workload and discussed matters such as dispensing incidents. They worked closely with the pharmacy owner and felt they could raise concerns and report problems. The supervisor met with the pharmacy owner each month and the owner frequently visited the pharmacy.

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 premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing. And hand sanitising gel was available. The pharmacy had sufficient space for dispensing activities and enough storage space for stock, assembled medicines and medical devices. Team members kept the floor spaces clear to reduce the risk of trip hazards. And there was restricted public access to the dispensary during the pharmacy's 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 obtains 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 to access services. Its website provided people with information on the services offered, the contact details of the pharmacy and its opening hours.

The pharmacy provided multi-compartment compliance packs to help around 35 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. And they used a dedicated area of the pharmacy to prepare the packs. The team usually ordered prescriptions for the medicines to be dispensed into the packs a week before supply to allow time to deal with issues such as missing items. And they contacted the person to check whether they needed medicines that were not supplied in the packs before they ordered the prescriptions. Each person had a record listing their current medication and dose times. As part of dispensing, the team recorded the descriptions of the medicines 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. Occasionally the pharmacy received copies of hospital discharge summaries which the team members checked for changes to treatment. And they liaised with the person's GP team when changes occurred to make sure prescriptions were updated. Team members contacted people to advise them of a change to their medication, so they were aware when they received the updated packs.

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. There were checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample of dispensed medicines found that the team completed both 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. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to provide people with when required. The pharmacy kept a record of the delivery of medicines for the team to refer to when queries arose. Due to risks linked with COVID-19 the delivery driver did not ask people to sign for receipt of their medication. And was advised by the team when a person reported to the pharmacy that they had COVID-19. So, the driver could take appropriate action such as leaving the medicine on the person's doorstep before moving away to watch them pick up the medication. The pharmacy used the postal service 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 clearly 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. Team members explained how they 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 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 help 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 pharmacy 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.