General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medichem Pharmacy, St Martins House, 210-212 Chapeltown Road, Leeds, West Yorkshire, LS7 4HZ

Pharmacy reference: 9010885

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

The pharmacy is in a large medical centre in a suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. And it supplies medicines in multi-compartmental compliance packs to help people take their medication. The pharmacy offers a repeat prescription ordering service. And it delivers medicines to people's homes. The pharmacy supplies over-the-counter products via a minor ailments scheme.

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	1.2	Good practice	The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. The team reviews and updates the tools used to capture errors to enable all team members to look for patterns. And for them to act to prevent the same mistakes from happening again. The team shares incidents with colleagues from other pharmacies to help reduce errors.
2. Staff	Standards met	2.4	Good practice	The pharmacy supports an open and honest culture with the team members. They openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacy team members look for ways to improve how they work. And have introduced processes that encourage them to focus on the task at hand whilst ensuring they complete key activities.
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 has systems to support the team to identify and manage the risks associated with its services. The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. The team reviews and updates the tools used to capture the information from errors. This enables all team members to look for patterns. And for them to act to prevent the same mistakes from happening again. The team shares incidents with colleagues from other pharmacies to help reduce errors. The pharmacy has written procedures that the team follows. And it reviews and amends them following an incident. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy keeps most of the records it needs to by law. And it has adequate arrangements to protect people's private information.

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. The team members had read and signed the SOPs signature sheets to show they understood and would follow them. Following an error with a multi-compartmental compliance pack the pharmacist manager had updated the SOP covering this activity. The update included the incorporation of an extra accuracy check. 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 errors. Each team member had their own records to capture these errors. The pharmacist manager had altered the records to include the cause of the error. And what actions the team member would take to prevent the same mistake from happening again. A sample of the error records looked at found the team captured details of what had been prescribed and dispensed to spot patterns. For example, one entry captured the dispensing of the wrong type of cream. The team member involved identified the cause as rushing and in future they were to double check the item selected. The pharmacist manager undertook a monthly review of each team member's record. And discussed this with the team member. The pharmacist manager captured the outcome of the review and the discussion on to the team member's record. Details from the reviews included the team member taking on less tasks. So, they could free up more time for themselves. And to focus on dispensing rather than breaking off to answer the telephone. The pharmacist manager didn't gather the information from the reviews into one monthly report. So, the team members could further spot any patterns with errors. And provide them with the opportunity to act to reduce common mistakes. The pharmacy recorded dispensing incidents. All team members were made aware of the error for their individual learning. And for them to discuss how they could prevent similar incidents. The pharmacist manager had updated the incident report to include reflections on the error. And the steps taken by the team to prevent a reoccurrence. Following an error with co-beneldopa and co-careldopa medicines the team members had separated the two products. And attached notes to the shelves holding these items to prompt them to check the medicine selected.

The pharmacist manager had also asked the GP team to include the brand on the prescriptions for the person who received the wrong medicine. So, the team members had an extra prompt to check the medicine they had dispensed.

The pharmacist manager completed an annual patient safety report. The recent report focused on an error with multi-compartmental compliance packs supplied to one patient. The report referred to the updated SOP and the development of a responsibility plan for the team. So, all the team knew what key tasks had to be completed. And to enable the team members at busy times to reduce the risk of rushing by prioritising tasks. The team listed the key tasks on a notice board in the dispensary for everyone to refer to when they had free time from activities such as dispensing. The report included advice given to the team members to do a self-check of the dispensed medicines before passing them to the pharmacist. The report listed the team's priorities for the next 12 months. These included the dispensary team looking at ways to be more efficient and knowledgeable. And to review every step of the journey of the person accessing the pharmacy services. The pharmacy teams from all the pharmacies in the company shared dispensing incidents with each other. And the steps the team involved had taken to stop the same error from happening again. For example, another team had shared an error with colchicine which resulted in this pharmacy team attaching a note to the shelf holding colchicine to prompt a check of the dose of this medicine. The team members also attached a note to the shelf with methotrexate to remind them that the dose was weekly. And they used notes to highlight medicines that looked and sounded alike (LASAs). The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it 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.

A sample of 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. The pharmacy kept most records of private prescription supplies in accordance with legal requirements. The records of 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 pharmacy had a procedure covering the requirements of data protection legislation. And the team had signed confidentiality agreements. The team members had received information governance training. But they had not completed any training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the General Data Protection Regulations. And it had a leaflet providing people with details on how the pharmacy protected their confidential information. The team separated confidential waste for shredding offsite.

The pharmacy had a procedure for the team to follow when safeguarding concerns arose. The team members had read and signed the procedure to show they understood and would follow it. The team had access to contact numbers for local safeguarding teams to report a concern. The pharmacist had completed level 2 and level 3 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery drivers reported concerns to the pharmacy team about people they delivered medicines to. And the team responded appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And the team members support each other in their day-to-day work and training needs. The pharmacy provides feedback to team members on their performance. So, they can identify opportunities to develop their skills and knowledge. The pharmacy supports an open and honest culture with the team members. They openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacy team members look for ways to improve how they work. And have introduced processes that encourage them to focus on the task at hand whilst ensuring they complete key activities.

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 pharmacy pre-registration student, a full-time trainee pharmacy technician, a part-time qualified dispenser and two part-time trainee dispensers. Four delivery drivers worked across the pharmacies in the company. At the time of the inspection the pharmacist manager, the pharmacy pre-registration student, the trainee pharmacy technician, the qualified dispenser and one of trainee dispensers were on duty. The course for the trainee dispensers included medicines counter assistant training. The pharmacy gave the trainees time to complete their courses. The pharmacist manager was training the team to complete key tasks such as checking the balances in the controlled drugs register. So, at times when the team members were busy, or colleagues were on holiday such jobs were not missed.

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 team often referred queries from people to the student as part of their learning and development. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. The team used the opportunity to agree outcomes such as completing their training. And to discuss personal objectives such as delegating tasks to colleagues. Each team member had their own training folder. The folder contained a list of the training the team member had completed. And the outcome from their performance review. The pharmacy occasionally held huddles to ensure all team members had up to date information.

The team members could suggest changes to processes or new ideas of working. And the pharmacy had a whistleblowing policy that the team had read and signed. The pharmacy had targets and incentives for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. And the pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic with separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. There was enough storage space for stock, assembled medicines and medical devices. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had a sound proof consultation room for private conversations.

The premises were secure. And the pharmacy had restricted access to the dispensary during the opening hours. 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 provides services that support people's health needs and it mostly manages its services appropriately. It gets its medicines from reputable sources and it stores and manages its medicines appropriately. The pharmacy team takes care when dispensing medicines in to multi-compartmental compliance packs to help people take their medication. And it keeps records about prescription requests up to date. So, this enables the team to deal with any queries effectively. The pharmacy delivers medication to people's homes. But the delivery drivers don't always get people to sign for the receipt of their medicines. And they sometimes post people's medicines without having written consent to do this. So, it may be difficult to resolve any queries or know the person has received their medicine.

Inspector's evidence

People entered the pharmacy through the medical centre. Access was via steps or a ramp, both with handles and 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 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 provided multi-compartmental compliance packs to help around 150 people take 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 usually ordered prescriptions a week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The team had a list of people who had the packs. The list recorded when the supply was due and when the team had ordered the prescriptions. This enabled the team to identify missing prescriptions and to chase them up with the GP team. The pharmacist manager was working with the GP team to move to repeat dispensing for these prescriptions. So, the pharmacy team members could access the prescriptions when they needed them rather than when the surgery released them. The team currently managed this by preparing the packs in advance and checking them. And then doing a final check when the prescription arrived. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the record. And queried any changes with the GP team. The team used two sections of the dispensary to dispense the medication. The team picked all the stock needed for the pack before dispensing. The pharmacist checked the medicine picked and marked each item on the prescription to show this had happened. Unmarked items on the prescriptions indicated medicines that were dispensed from bulk containers at the time of dispensing. The pharmacist when doing the final check referred to the bulk containers and the packaging from smaller packs. 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 used a notice board in the dispensary to record people admitted in to hospital. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. And contacted the GP team for prescriptions when required.

The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions four days before supply. This gave time to receive the prescriptions, order stock and dispense the prescription. The team members recorded when they had requested the prescriptions. And they checked the record 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 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 pharmacy team had not completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack containing information to pass on to people when required.

The pharmacy used clear bags to hold dispensed fridge lines. This allowed the team, and the person collecting the medication, to check the supply. 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. The pharmacy kept a record of the delivery of medicines to people. This included a section to capture the signature from the person receiving the medication. But many records only had the name of the delivery driver rather than the signature of the person receiving the medication. So, there was nothing to prove that the driver had handed over the medication. Several entries stated the driver had posted the medicine. The pharmacy did not have up to date written consent from the person for the driver to post their medicines. So, the team would not know it was safe to do this.

The pharmacy team checked the expiry dates on stock. And it kept a record of this. The last date check was on 11 July 2019. The team highlighted the expiry date on the packaging for 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 morphine oral solution with 90 days use once opened had a date of opening of 05/06/19 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 procedures, equipment and a software upgrade to meet the requirements of the Falsified Medicines Directive (FMD). The team members were scanning any FMD packs they came across. 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 it mostly protects 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 large fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electronic equipment.

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 generally held private information in the dispensary and rear areas, which had restricted access. But some completed consent forms for pharmacy services containing people's confidential information were found on a filing tray in the consultation room. 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.