

# Registered pharmacy inspection report

**Pharmacy Name:** Bradford Delivery Chemist, Former Windmill Gym,  
Ebenezer Place, Bradford, West Yorkshire, BD7 3DZ

**Pharmacy reference:** 9011238

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 11/11/2024

## Pharmacy context

The pharmacy is in a business centre in the suburbs of Bradford city centre. It has a distance selling NHS contract. Pharmacy team members dispense NHS prescriptions and deliver them to people's homes. They provide medicines to some people in multi-compartment compliance packs. And they provide medicines to people living in care homes and nursing homes. The pharmacy has a website, [www.bradforddeliverychemist.co.uk](http://www.bradforddeliverychemist.co.uk), which is managed by a third-party company on the pharmacy's behalf.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy adequately identifies and manages risks. It has the written procedures it needs to help team members provide services safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss the mistakes they make so that they can learn from them. But they don't always follow documented procedures to help capture key information or analyse these records, so they may miss some opportunities to learn and improve.

### Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to help pharmacy team members manage the risks associated with its services. The pharmacy owner reviewed the SOPs every two years. They had last reviewed them in 2023. And pharmacy team members had signed to confirm they had read and understood the procedures since the last review. The SOPs also contained version control information, so team members could be clear they were working with the most current SOP.

The pharmacy used automated dispensing technology to dispense approximately 75% of the multi-compartment compliance packs it provided to people living in care and nursing homes. There was a set of SOPs available for team members to refer to, to manage the risks of using the technology. The pharmacy had completed risk assessments to help manage the risks of providing some services, including for managing waste medicines, removing medicines from the manufacturers original packaging, and delivering medicines to people living in care and nursing homes. And in their own homes. And these assessments had been documented to help team members reflect and reassess risks later.

Pharmacy team members recorded mistakes that were identified before people received their medicines, known as near misses. There was an SOP to help them do this effectively. They discussed their mistakes and why they might have happened, and they recorded some information about each error. Pharmacy team members did not always record much information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed, and changes made. For example, by adding extra checks into their dispensing process to help prevent errors with quantities. The owner explained that they looked at the data collected about near miss errors each month to establish any patterns. But they did not record their findings. This was discussed and they gave their assurance that they would record more regular analyses to help inform the changes they made in response to errors. A recent pattern of errors identified related to the automated dispensing technology not recognising different brands of some medicines when it performed a visual scan of the medicines. The owner had changed the SOP for handling new medicines and brands received in the pharmacy. And this had helped ensure that information about new medicines was added to the system and the medicines properly scanned before being used, and to help prevent errors and delays. The pharmacy had a process for managing and recording dispensing errors, which were errors identified after people had received their medicines. The examples seen provided sufficient information about what had happened. And information about causes and the changes team members had made to prevent a recurrence.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It

advertised a complaint's procedure to people on its website. But the information available did not provide details of key people to direct complaints to, such as the superintendent pharmacist. So, people may not always know what to do if they want to raise a concern. The pharmacy usually collected feedback from people via email or verbally. And there were no recent examples of any changes it had made in response to people's feedback.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members checked most of these registers against the physical stock quantity approximately each month. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. And it maintained a responsible pharmacist record, which was up to date. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily. And they accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials securely in the pharmacy. Team members collected confidential waste in dedicated bins. The bins were locked and emptied regularly by a waste disposal contractor who took the waste for secure destruction. The pharmacy had a documented procedure to help pharmacy team members manage sensitive information correctly. Team members explained how important it was to protect people's privacy and how they would protect confidentiality.

The pharmacy had a documented procedure for dealing with concerns about children and vulnerable adults. A pharmacy team member gave some examples of signs that would raise their concerns about the welfare of vulnerable children and adults. And they explained how they would refer any concerns to the pharmacist. The team also explained how they would use the internet to find the most up-to-date local safeguarding contacts to refer their concerns to, especially for people they provided medicines to that did not live in the area local to the pharmacy. Team members completed formal safeguarding training every two years.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete some additional training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they are confident their suggestions will be considered.

### Inspector's evidence

At the time of the inspection, the pharmacy team members present were the regular RP, who was also the pharmacy owner, four trainee pharmacy technicians, two qualified dispensers, and two trainee dispensers. The pharmacy also employed a qualified pharmacy technician who was trained to perform the final accuracy check of prescriptions, and four delivery drivers. Team members had the right qualifications for their roles. And they managed the workload well during the inspection. Pharmacy team members completed training ad hoc by completing online training modules, reading various materials, and discussing topics with colleagues. They received an appraisal with the pharmacist every year, where they discussed their performance and set objectives to work towards. They explained how they were supported by the RP to meet their objectives.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. They explained how they would raise professional concerns with the pharmacist or SI. They felt comfortable raising concerns, and confident that their concerns would be considered. And that changes would be made where they were needed. The pharmacy had a whistleblowing policy that team members could use to raise concerns anonymously. The policy was not easy to find, but team members also knew how to raise concerns outside their organisation, such as with the GPhC or the NHS.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it offers. And pharmacy team members properly secure the pharmacy to prevent unauthorised access.

### Inspector's evidence

The pharmacy was in a shared business unit, and it could not be directly accessed by the public. It was properly secured, and pharmacy team members controlled access to the pharmacy to help prevent unauthorised access during working hours. The pharmacy had various rooms that team members used for varying purposes including office space and storage.

The pharmacy was tidy and well maintained. It had defined areas for dispensing and checking and there was a defined workflow in operation. The pharmacy's floors and passageways were free from clutter and obstruction. It had a clean, well-maintained sink used for medicines preparation. There was a toilet, a sink with hot and cold running water and other facilities for hand washing. And it had a separate kitchen area where team members could prepare food and drinks. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional and suitable for the services being provided.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are accessible to people. It has systems in place to help it provide services safely and effectively. The pharmacy sources its medicines appropriately. And it generally stores and manages its medicines as it should. Pharmacy team members provide people with advice and information about their medicines. And they use the available technology well to help them provide medicines to people safely.

### Inspector's evidence

People did not visit the pharmacy to access services. They communicated with the pharmacy by telephone and email. The pharmacy had a website, [www.bradforddeliverychemist.co.uk](http://www.bradforddeliverychemist.co.uk), where it provided its contact details and information about its services. Pharmacy team members could provide large print labels for people with visual impairment. They said they would communicate in writing with people with a hearing impairment. But there were no examples of them providing these adjustments for people.

The pharmacy used automated technology to dispense approximately 75% of its medicines into multi-compartment compliance packs for people. Most of these packs were provided to people who lived in care homes and nursing homes. And the pharmacy had current SOPs available to help team members manage the risks of using the technology. Prescriptions for medicines dispensed in packs were ordered by each home then sent to the pharmacy electronically. Team members screened each prescription to make sure they matched the pharmacy's existing records, and to identify any changes or new medicines. Changes were highlighted to the pharmacist to consider during their clinical check of each prescription. And they annotated the prescriptions to confirm they had completed their checks. Once these checks had been completed, the prescriptions were passed to other team members to prepare and dispense.

Pharmacy team members regularly removed medicines from the manufacturer's original packaging to be able to place medicines in the automated dispensing system. They usually did this in bulk and placed the loose tablets and capsules in bulk containers ready to be placed in the system. Team members cleaned each bulk container between each batch. And they attached information to confirm the medicine's identity, its manufacturer, batch number and expiry date. They explained that medicines prepared and stored that way would usually be used within a month. And they used online resources to confirm the stability of medicines once they had been removed from the manufacturer's original packaging. They gave some examples of medicines that could not be removed from original packaging or dispensed via the automated system, such as valproate and cyanocobalamin.

Team members transferred bulk medicines into canisters for dispensing and these were loaded into the system for dispensing of the packs. Each canister had parts that were designed to be a unique shape specific to a particular brand of a medicine. This meant it could only be used to dispense that medicine made by that manufacturer. Not all medicines were dispensed from the canisters. Pharmacy team members manually added some medicines to the system's removable tray to be dispensed into packs from there. After the medicines were dispensed into packs, the pharmacy used photographic identification technology to scan the medicines in each compartment. The dispenser completed a manual, visual check of any pack that the system highlighted as having a potential inaccuracy or

anomaly. Once completed, team members attached a backing sheet to each pack, so people had written instructions of how to take their medicines. They included descriptions and photographs of what the medicines looked like, so they could be identified in the pack. They provided people with patient information leaflets about their medicines each month if they received packs in their own homes. Or they provided care and nursing homes with updated leaflets every six months. A pharmacist or accuracy checking pharmacy technician (ACPT) carried out a final accuracy check of each pack before they were stored ready for delivery. Each pack sent to a care or nursing home was provided with a medicines administration record (MAR), either on paper or electronically, for staff to use to record administration of medicine to people in their care. The MAR contained people's photographs to help make sure medicines were administered to the correct person. And they contained images of the medicines so they could be easily identified during administration. The pharmacy retained information about each pack dispensed using the automated technology for approximately 18 months after the pack was provided. This included images of the visual scan of each pack to help accurately deal with future queries or concerns.

The pharmacist counselled people receiving prescriptions for valproate if they were at risk. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They advised they would also check if they were on a pregnancy prevention programme and taking regular effective contraception. The pharmacist did not record these conversations with people to help with future queries. But they had completed an audit in 2023 to help identify people at risk. Team members were aware of the need to provide valproate in the manufacturer's original packaging.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This provided an audit trail of the people involved in the dispensing process. They used baskets during dispensing to separate peoples' medicines and prescriptions, to help prevent them being mixed up. The pharmacy obtained medicines from licensed wholesalers. It stored medicines tidily on shelves. And it kept medicines in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The CD cabinet was tidy and well organised. And out-of-date and patient-returned CDs were segregated.

The pharmacy delivered medicines to people, and it recorded the deliveries it made using an electronic tracking system. The delivery driver scanned a QR code on the medicines bag when they collected them for delivery. The QR code was scanned again at the point of delivery and the system alerted the driver if they were delivering the package at the incorrect location. Drivers collected signatures on a handheld device for each delivery. And they also took a photograph of the location where they delivered a CD. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The delivery driver also collected signatures from staff at care and nursing homes to confirm the homes had received the required medicines for each person.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. The pharmacy stored CDs securely in a locked cabinet. The cabinet was generally tidy, but some medicines were stored together in large trays, which increased the risks of team members selecting the wrong medicines when dispensing. This was discussed with the owner, and they gave their assurances they would reorganise how these medicines were stored to reduce the risk of a picking error. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records were within acceptable limits. Pharmacy team members checked medicine expiry dates every month, and they recorded their checks. They highlighted packs of medicines due to expire in the next three months. These items were removed from the shelves during the month before their expiry. The pharmacist explained how they acted when they received a drug alert or manufacturers recall by email. And they



recorded these actions.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the necessary equipment available for the services it provides. It has some equipment available to help reduce its carbon footprint. And it manages and uses its equipment in ways that protect people's confidentiality.

### Inspector's evidence

The pharmacy had the necessary equipment to restrict access to the premises. And it had the equipment it needed to provide the services offered. It had various pharmacy reference texts and use of the internet. And it had suitable containers available to collect its confidential waste. It kept its computer terminals in the secure pharmacy, and these were password protected. It had a set of clean, well-maintained measures available for medicines preparation. And a separate set of measures used to exclusively measure and prepare doses of methadone. The pharmacy had a maintenance contract with the manufacturer of the system used to dispense packs. The system was serviced once a year. And support technicians were available quickly if the system broke down.

The pharmacy used four electric vans to deliver medicines to people. And it had installed the necessary EV chargers to support this. The owner explained how they had made the decision to switch to electric vehicles based on cost savings. But they had also been encouraged by the reduced environmental impact, particularly as the business expanded and they were delivering medicines further afield. The owner also explained how the electric vans had cost the pharmacy less in maintenance because they did not break down as often as other vehicles they had used in the past. They had received positive feedback from some homes they provided services to, encouraging the pharmacy's environmental consciousness. The pharmacy was considering adding solar panels to the pharmacy to further reduce their carbon footprint.

### 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.