General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prime Health Pharmacy, Unit 10 Flexspace, Albion Park, Armley Road, Leeds, West Yorkshire, LS12 2EJ

Pharmacy reference: 9011282

Type of pharmacy: Internet

Date of inspection: 27/04/2021

Pharmacy context

This pharmacy provides its services at a distance and access to the premises is generally 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. People can purchase some medicines from the pharmacy website. The pharmacy was inspected during the COVID-19 pandemic.

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 generally identifies and manages the risks associated with its services including the risks from COVID-19. The pharmacy completes the records it needs to by law and it protects people's private information properly. The pharmacy identifies potential risks to the safe dispensing of prescriptions and it acts to prevent errors. But it doesn't keep records of errors for the team members to review and improve their practice.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments to identify the personal risk to all team members of catching the virus. 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 had access to Personal Protective Equipment (PPE) and all the team members wore face masks throughout the inspection. The team regularly took a COVID-19 lateral flow test.

The pharmacy had a range of standard operating procedures (SOPs) written by the regular pharmacist and dated July 2019. These provided the team with information to perform tasks supporting the delivery of services. And formed part of the risk assessment of pharmacy services completed by the pharmacists. The two pharmacists and part-time dispenser had read the SOPs and signed a signature sheet to show they understood and would follow them. However, the signature sheet was not available at the time of the inspection. The pharmacist contacted the inspector after the inspection to advise the sheet could not be found so a new one had been developed.

On most occasions the pharmacist when checking prescriptions and spotting an error discussed it with the dispenser before correcting the mistake. The pharmacy had a SOP covering the actions to take when an error was identified during the prescription checking process. The pharmacy kept a log of these errors known as near misses. The log didn't have any entries which the pharmacist explained was due to very few near miss errors occurring. The pharmacy had a procedure for managing dispensing incidents that were identified after the person received their medication. The pharmacist explained there had never been any such incidents to report. The pharmacists and dispenser discussed the risk of errors with medication that looked and sounded alike (LASA). And they ensured common LASA products were separated. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And the pharmacy website displayed details on how to raise a concern and give feedback. The pharmacy had received positive feedback from people who had attended for the seasonal flu vaccination service. Several people who had attended for the flu vaccination service contacted the pharmacy asking if it was providing the COVID-19 vaccination service.

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 met legal requirements. The pharmacy website provided details about the confidential information kept and how the pharmacy complied with the General Data Protection Regulations (GDPR). The team separated confidential waste for shredding onsite. The pharmacy team members had access to contact numbers for local

safeguarding teams. The pharmacist had 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 but had not had the occasion to offer it or raise a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has an experienced team with the qualifications and skills to support its services. Team members work well together and support each other in their day-to-day work. They frequently discuss ideas to enhance the delivery of the pharmacy's services. Pharmacy team members receive informal feedback on their performance and they have some opportunities to complete ongoing training.

Inspector's evidence

The Superintendent Pharmacist (SI) and a regular pharmacist covered the opening hours. A part-time qualified dispenser with several years of experience supported the pharmacists. At the time of the inspection the regular pharmacist and the dispenser were on duty. During the pandemic the team had worked well together to ensure pharmacy services were not affected. The pharmacist and dispensers worked together to ensure most prescriptions were completed before the dispenser finished for the day.

The dispenser had access to extra training such as new NHS services. The three team members regularly held meetings to discuss the pharmacy services and share any issues. The pharmacists used a communications book to share key messages with each other. The dispenser received in the moment informal feedback and could suggest changes to processes or new ideas of working. The dispenser had shared their experience of working with other pharmacy teams to suggest improvements to the compliance pack service. The pharmacy did not set targets for the services offered. The team worked together to identify opportunities to introduce new services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. The pharmacy has adequate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. The team shared the responsibility of regularly cleaning the pharmacy which was captured on a team rota. The pharmacy had enough storage space for stock, assembled medicines and medical devices. 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. The pharmacy had a large, soundproof consultation room that the pharmacists used when providing services such as the seasonal flu vaccination.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are generally well managed so people receive appropriate care. The pharmacy has appropriate systems in place to support the safe and effective supply of medicines in multi-compartment compliance packs. 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 that people could not access the pharmacy premises directly unless they were attending for services such as the flu vaccination service. 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 pharmacists provided people with advice on taking their medicines either by speaking to them on the telephone or when delivering their medicines. The pharmacist was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) but the pharmacy did not have anyone prescribed valproate who met the criteria. The team had access to PPP information to pass on to anyone who needed the information. The pharmacy did not routinely ask people on other high-risk medication such as warfarin about their medicines or recent test results.

The pharmacy website enabled people to purchase over-the-counter medicines from a limited range kept in the pharmacy. The person was directed to an online questionnaire which was submitted to the pharmacist to check. This was mostly for products containing medicines that were liable to misuse such as co-codamol. Requests for other OTC products such as ibuprofen triggered an email to the pharmacists who contacted the person for further information if needed. The website had undergone a recent upgrade which had temporarily removed the questionnaire facility. Whilst the IT fix was taking place the pharmacists had changed the status of the OTC products to out of stock to prevent anyone from attempting to purchase the medication. The website didn’t supply OTC codeine linctus but the pharmacist reported several phone calls from people asking if the product could be purchased.

The pharmacy provided multi-compartment compliance packs to help around 17 people take their medicines. And it also provided this service to people living in a local care home. The pharmacy supplied packs monthly or weekly depending on the person’s needs. The dispenser managed the supply of packs and divided the preparation and supply of the packs across the month. The dispenser kept a list of people due each week for her and the pharmacists to keep track of. The team usually ordered the prescriptions one 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 recorded the descriptions of the products within the packs to help people identify the medicines in the packs. The team supplied the manufacturer’s packaging leaflets so people had information about their medicines. The pharmacy used baskets to hold completed packs and the empty container the medication was removed from. The pharmacist referred to the empty containers when checking the packs. Information such as a hospital admission or missing medication was written on notes and kept in the basket with the person’s prescription for all the team to see.

The 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 pharmacy had

checked by and dispensed by boxes on the dispensing labels. These recorded who in the team had dispensed and checked the prescription and provided an audit trail. A sample looked at found that the team completed the boxes. When one of the pharmacists dispensed a prescription, the other pharmacist checked the prescription the following day unless it was an urgent prescription. If the pharmacist had to check their own dispensing a mental break was taken between dispensing and completing the final check.

The three team members delivered medicines to people either during the day or after the pharmacy closed. The pharmacy didn't keep a record of the delivery of medicines to people. Due to the pandemic the team member delivering the medicine did not obtain a signature from the person receiving the medication. Most deliveries were in the local area but a few deliveries were to people living some distance away. In these circumstances the pharmacy used a recognised delivery company that provided a tracking service. The team contacted the person before the delivery was due out to confirm someone would be at home to receive the medication. If the person was not at home the team or delivery company left a note advising the person a delivery had been attempted. The driver from the delivery company also contacted the pharmacy team who rang the person.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and placed coloured dots on medicines with a short expiry date. But it did not record when the date checking had taken place. No out-of-date stock was found. The team recorded fridge temperatures each day and a sample were within the correct range. 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 pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. 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 pharmacists received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA). And they took appropriate action in response to the alerts.

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 online references to provide the team with up-to-date clinical information. The pharmacy used CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures. The 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.