

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Express, 213 Barnsley Road, Wakefield, West Yorkshire, WF1 5NU

Pharmacy reference: 9011480

Type of pharmacy: Community

Date of inspection: 10/06/2021

Pharmacy context

This community pharmacy is amongst a small parade of shops on a main road leading from Wakefield city centre. The pharmacy relocated from smaller premises in November 2020. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help several people take their medicines. And it delivers medication to people's homes. 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	2.2	Good practice	The pharmacy actively encourages and supports team members to develop their knowledge and skills. It provides a range of opportunities for team members to identify their training needs and it gives them protected time to complete their training.
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 up-to-date 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.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments for all team members to identify their personal risk of catching the virus. The pharmacy's retail area was large enough to provide space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The pharmacy displayed a poster on the front door reminding people to wear a face covering and had hand sanitiser at the front door for people to use. The pharmacy had installed a plastic screen on the pharmacy counter to provide the team with extra protection. The size of the dispensary enabled team members to mostly adhere to social distancing requirements. The team members wore Personal Protective Equipment (PPE) face masks. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and many tests had been supplied.

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 team members had read the SOPs but not all 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. The team referred queries from people to the pharmacist when necessary.

The pharmacist or accuracy checking technician (ACT) when checking dispensed prescriptions and spotting an error informed the team member of the error rather than inviting them to find it themselves. The pharmacy kept records of these errors known as near miss errors. The pharmacist or ACT rather than the team member involved created the record. This meant the team member didn't have the opportunity to record their thoughts on the cause of the error and how to prevent the error from happening again. The details on the near miss record enabled the team to identify patterns when the same medicines were involved. The record had a section to record the learning points. A sample of records showed varied learning points such as the medicines involved had similar names. However, the section to record the actions taken to prevent the error from happening again had the same response for each entry, that the error had been discussed. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. And it kept electronic records of these errors. The records included details on the cause of the error and the actions taken by the team to prevent the error from happening again. All team members, whether directly involved with the error or not, were informed of the error to ensure they were aware of it and could learn from it. The team had placed warning stickers on the shelves holding medicines that were at risk of being picked in error as they looked and sounded alike (LASA). For example, hydroxyzine and hydralazine. The stickers prompted the team to double check the item selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services.

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. The RP record had several entries where the time the RP signed out was not recorded. The CD registers were kept electronically. The system captured the current stock balance for each CD register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. The pharmacy had procedures for managing confidential information and the team was aware of the requirements of the General Data Protection Regulations (GDPR). The pharmacy information leaflet contained details of the confidential data kept at the pharmacy and how it protected this information. However, there were no leaflets available for people to see this information and the pharmacy was not displaying a privacy notice. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And team members had completed Dementia Friends training. The team responded well when safeguarding concerns arose. The delivery drivers reported to the pharmacists any concerns they had about people they delivered to. The pharmacists then took appropriate action such as contacting the person's GP. The team members were aware of the Ask for ANI (action needed immediately) initiative.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support its services. And it is good at providing team members with opportunities to develop their knowledge and skills. The team members support each other in their day-to-day work. And they identify areas for improvements to the delivery of pharmacy services.

Inspector's evidence

The Superintendent Pharmacist (SI) and the other pharmacist owner covered the opening hours. The two pharmacists worked together most days and arranged locum pharmacist cover when one was on holiday. The pharmacy team consisted of a full-time pharmacy technician who had recently qualified as an accuracy checking technician (ACT), a full-time trainee pharmacy technician, one full-time dispenser, two part-time dispensers and two delivery drivers. At the time of the inspection the two pharmacists, the ACT, the trainee pharmacy technician, the full-time dispenser, one of the part-time dispensers and one of the delivery drivers were on duty. Team members were given protected time for their training and trainees were encouraged to ask the experienced team members for help with any queries they had.

As the pharmacy business grew the SI and the other pharmacist owner recognised the importance of delegating tasks amongst the team. The pharmacists identified team members with the skills for the roles that could support specific tasks and had discussed the roles with these team members. The ACT had recently been appointed as dispensary manager after expressing an interest in the role. The ACT's managerial role included organising the team's daily and weekly tasks and interviewing applicants for team roles. The pharmacists recognised the trainee technician's IT skills and offered her the role of managing the day-to-day IT requirements for the pharmacy. This included regularly monitoring incoming emails and updating the NHS PharmOutcomes system. The pharmacists had trained all the dispensers to contact medical teams directly with common prescription queries rather than passing it to the pharmacist to do. Such queries included contacting the medical team on receipt of a prescription for anti-inflammatory medication when the person had not been prescribed medication to protect their stomach. This ensured the query was raised early in the dispensing process and a response received in time before the supply to the person.

The pharmacy provided team members with a range of training modules to keep their knowledge up to date. The team was alerted to new training courses via emails. The team could request specific training. The trainee technician had asked to be enrolled on to a first aid training programme and the ACT had expressed interest in training to administer the flu vaccination. The pharmacy provided team members with informal feedback on their performance. And it held regular team meetings. Team members could suggest changes to processes or new ideas of working. The pharmacy had changed the paperwork accompanying compliance packs. The full-time dispenser who dispensed many of the packs had raised concerns that the generating of the new paperwork increased the time it took to process the packs. The dispenser explained to the team the previous system was quicker and provided the same information for people receiving the packs as the new process. The team agreed to return to the previous system.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. The pharmacy has good facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. During the pandemic the team regularly cleaned the pharmacy particularly touch points in the retail area. The pharmacy displayed posters explaining effective hand washing techniques. It had separate sinks for the preparation of medicines and hand washing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had restricted access to the dispensary during the opening hours.

The pharmacy had a large, soundproof consultation room used for private conversations with people and for services such as the flu vaccination. During the pandemic the team occasionally used this for private conversations with people and cleaned the room after use. The room contained a sink and hand sanitiser. The pharmacy provided people receiving their medication as a supervised dose within a separate room to take their medication in private. Due to the pandemic the pharmacy asked people to enter the room one at a time unless they were in a couple.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help 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 them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People entered the pharmacy directly from the street. The window displays detailed the opening times and the services offered. The pharmacy had recently extended its opening hours to three hours on a Saturday morning so people could access its services for a longer period of time. The team updated the notice on the front door to show this. Since opening on a Saturday morning the pharmacy had seen an increase in referrals for minor illness consultations via the Community Pharmacist Consultation Service (CPCS). The pharmacist monitored the CPCS referrals to ensure they were appropriate. The team had access to the internet to direct people to other healthcare services when required. One of the dispensers spoke Polish which reflected the language spoken by several people in the local area who used the pharmacy. This helped the team to ensure that people understood information such as dose instructions. The pharmacy had recently introduced a mobile phone App for people to download. This enabled people to order and track their NHS prescriptions.

The pharmacy provided multi-compartment compliance packs to help around 280 people take their medicines. 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 into the packs. The team created a list each Friday of the packs that were due to be dispensed the following week. The team checked the list against the prescriptions received to identify any that needed to be chased up. The ACT developed a record for the team to track the supply of packs to people and when the next set of prescriptions were due. The team recorded the descriptions of the products within the packs and supplied the manufacturer's patient information leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy occasionally received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes and the NHS discharge medicines service. The team checked the discharge summary for changes or new items and took appropriate action to ensure the person had the correct medication. The pharmacy also provided compliance packs to three care homes. The care home teams ordered the prescriptions and informed the pharmacy team of the medicines ordered. This meant the pharmacy team could check the received prescriptions to make sure all the medication ordered had been prescribed.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacy prepared the doses using an electronic pump. The pump was linked to a laptop that the team updated with the doses on receipt of a new prescription. The pump was regularly cleaned and calibrated to ensure the correct amount of medication was supplied each time. 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). The pharmacy didn't have anyone prescribed

valproate who met the PPP criteria but it had PPP information available to provide to people when required. The pharmacists asked people on other high-risk medication such as warfarin about their medicines or recent test results. And recorded relevant information on the person's electronic medication record (PMR).

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 found that the team completed both boxes. The pharmacy also had a quad stamp that the team used on the prescriptions. This provided an audit trail of who had clinically checked, accuracy checked, dispensed and handed out the medication. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and 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. During the pandemic the pharmacy had seen an increase in the number of people using its delivery service. The pharmacy had bought a second delivery van to support the increased number of deliveries. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. The pharmacy changed the regular delivery dates when people asked for a different day. Due to COVID-19 the delivery driver did not ask people to sign for receipt of their medication. The driver marked the sheet to show a delivery had been made. This meant the team had information to refer to if a person had questions about the delivery.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and kept a record of this. But the record was not available to view at the time of the inspection. 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 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 a range of CE equipment to accurately measure liquid medication. The pharmacy had a large fridge to store medicines kept at these temperatures. The fridge had a glass door that enabled the team to see the stock inside without prolong opening of the door.

The pharmacy 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 held private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.