

# Registered pharmacy inspection report

**Pharmacy Name:** Harehills Pharmacy, Bellbrooke Surgery, Bellbrooke Avenue, Leeds, West Yorkshire, LS9 6AU

**Pharmacy reference:** 9011616

**Type of pharmacy:** Community

**Date of inspection:** 08/11/2022

## Pharmacy context

This pharmacy is in a large medical centre in a suburb of Leeds. The pharmacy's main activities are dispensing NHS prescriptions, delivering medicines to people's homes and selling over-the-counter medicines. The pharmacy provides the seasonal flu vaccination service.

## 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 generally identifies and manages the risks associated with its services. It completes the records it needs to by law and it mostly protects people's private information. The pharmacy provides its team members with training and guidance to help them respond to safeguarding concerns. The team acts appropriately when mistakes happen to help prevent future mistakes and improve the safety of the pharmacy services.

### Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept on a digital platform. The SOPs provided the team with information to perform tasks supporting the delivery of services. The team members had read the SOPs and signed a signature sheet to indicate they understood and would follow them. They demonstrated a clear understanding of their roles but when asked to show a sample of the SOPs they struggled to locate them.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. The pharmacy had a template to capture these errors and team members generally recorded their errors. A sample of completed records showed sufficient details were captured. For example, the team member's learning from the error and the action they'd taken to prevent the error from happening again. The pharmacy had a separate procedure for managing errors identified after the person had received their medicine, known as dispensing incidents. The pharmacy recorded the dispensing incident and sent a copy of the record to the head office team. A sample of dispensing incident reports found they were all delivery errors caused by one person receiving another person's medication. The reports detailed that the driver had re-read the SOPs. And was reminded, in accordance with the SOP, to always check the person's details before handing over their medication. The pharmacy occasionally completed a review of the errors and dispensing incidents to identify patterns. The team discussed how to prevent errors from happening again and had placed warning labels on shelves holding medicines that looked alike and sounded alike (LASA). These were used to prompt the team members when dispensing a prescription to check the medicine they'd selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services and a leaflet provided people with information on how to raise a concern.

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 completed regular balance checks of the CD registers to help identify errors such as missed entries. The team members had completed training about data protection and they separated confidential waste for shredding offsite. However, some prescriptions and completed compliance packs were found on the bench in the consultation room which the public had access to.

The pharmacy had safeguarding procedures for the team to follow and team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The delivery driver reported concerns about people they delivered to back to the pharmacy team who took appropriate action such as contacting the person's GP.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work and when completing their training. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training to develop their knowledge and skills.

### Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time dispenser, two full-time trainee dispensers, a full-time trainee medicines counter assistant and a part-time delivery driver. The trainee team members were given some protected time at work to complete their training and were comfortable asking experienced team members for support. One of the trainee dispensers was the pharmacy supervisor and had developed a team rota covering key tasks such as date checking. This ensured the team knew how to do these tasks and that the tasks were completed especially at times when team members were absent.

The pharmacy provided some additional training for the team members to help them broaden their knowledge. And it supported them to develop their skills through annual performance reviews and informal feedback. The team held regular meetings and team members could suggest changes to processes or new ideas of working. The team discussed information sent from the company's head office and the pharmacist shared details such as new services. The pharmacy supervisor used a recent meeting to discuss the process for counting the number of prescriptions dispensed each day so it was done without impacting on other tasks.

## Principle 3 - Premises ✓ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy premises were tidy and hygienic. In response to the COVID-19 pandemic the pharmacy had installed clear plastic screens on the pharmacy counter. It provided team members with separate sinks for the preparation of medicines and hand washing. There was enough storage space for stock, assembled medicines and medical devices and the team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a defined professional area where items for sale were healthcare related and an appropriately sized soundproof consultation room. The team used the room for private conversations with people and when providing pharmacy services. The pharmacy also had a separate, cordoned off area that provided privacy to people receiving their medication as a supervised dose. The pharmacy had restricted public access to the dispensary during the opening hours.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services which are easily accessible for people. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and appropriate to supply.

### Inspector's evidence

People accessed the pharmacy via an automatic door and a step-free entrance. The team offered a range of over-the-counter medicines and directed people to other healthcare services when required. The team discussed at a recent team meeting that the pharmacy didn't stock any vitamin products for people to buy. This meant they had to refer people elsewhere who requested a vitamin or when the team recommended a vitamin. So, the team ordered a range of vitamins which proved to be popular with people. The team monitored requests for over-the-counter medicines that were liable to be misused to ensure supplies were appropriately made.

The team provided people with clear advice on how to use their medicines. Some team members spoke Punjab and Arabic and the team accessed an online platform to translate other languages. This helped to ensure people received the correct information about their medication. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided to people. The pharmacy had an SOP focusing on valproate and the PPP but didn't have anyone prescribed valproate who met the PPP criteria. The pharmacy provided the seasonal flu vaccination against up-to-date patient group directions (PGDs) which gave the pharmacist the authority to administer the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. To manage the workload the team divided the dispensing of the medication across the month. And worked one week ahead of when the person needed their next supply to ensure people received their medication on time. The packs were dispensed at the company's offsite dispensary in accordance with its standard operating procedures. The pharmacy kept a record listing each person's current medication which the team used to identify any changes or missing items that were queried with the prescriber. Once the pharmacist had completed a clinical check of the prescription the team inputted the prescription details before submitting it to the offsite dispensary for assembly. The team at the offsite dispensary highlighted any incomplete prescriptions for the pharmacy team to complete. The packs arrived from the offsite dispensary with descriptions of the products recorded but the manufacturer's packaging leaflets weren't sent. So, the team printed the leaflets out and added them to the packs before they were supplied to the person. This meant people could identify the medicines in the packs and had information about their medication. The team stored the completed packs in a dedicated area where they could be easily located.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. And several doses were prepared using a pump linked to a laptop. The team inputted prescription information into the system on the laptop to ensure the pump measured the required doses and generated the correct labels. The medicine was poured into an unlabelled bottle attached to the pump. This meant details such as the batch number and expiry date of the medicine used were missing.

However, the team members usually kept the original bottles the medicine was poured from next to the pump so they could check the product when a safety alert about the medicine came through. The team regularly checked and cleaned the pump to ensure the correct doses were measured on each occasion. The pharmacy asked people to present at certain times for their doses. This gave the team time to prepare the pump at the start of the day and to clean it at the end of the day.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy's dispensing labels had boxes to record who in the team had dispensed and checked the prescription. A sample of completed prescriptions found that the team initialled both boxes. The pharmacy used fridge and CD stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. The delivery driver left a note informing people who were not at home that a delivery had been attempted and their medication had returned to the pharmacy. The team members stored the returned deliveries in a dedicated area so they could easily find them if people came to collect their medication.

The pharmacy obtained medication from several reputable sources and used a web-based ordering system for most supplies. This provided the team members with up-to-date information on the availability of medicines so they could act to ensure people were not without their medication. The team worked efficiently to check and store the medicines received from the wholesalers to make sure the dispensary benches and floor spaces were kept clear. The pharmacy team generally followed the pharmacy's procedures to ensure medicines were safe to supply. This included marking medicines with a short expiry date to prompt them to check the medicine was still in date. And usually recording the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines remained safe to use. The team checked and recorded fridge temperatures on most days and a sample of completed records found the readings were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored CDs in a 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 usually 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. It makes sure it uses its equipment appropriately to protect people's confidential information.

### Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. It had suitable equipment available for the services provided including a range of CE equipment to accurately measure liquid medication and a large pharmacy fridge. 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. And it had cordless telephones to enable the team to hold private conversations with people.

### 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.