

# Registered pharmacy inspection report

**Pharmacy Name:** Hyde Park Pharmacy, 22-24 Woodsley Road, Leeds, West Yorkshire, LS3 1DT

**Pharmacy reference:** 9011727

**Type of pharmacy:** Community

**Date of inspection:** 10/08/2023

## Pharmacy context

This community pharmacy is in a large suburb of Leeds. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. And it delivers medicines to people's homes. The pharmacy offers other NHS services including the Community Pharmacist Consultation Service (CPCS) and the Hypertension case finding service.

## Overall inspection outcome

### Standards not all 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
<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 not all met	4.3	Standard not met	The pharmacy does not always store its medicines in an organised and safe manner. Medication with short expiry dates is not routinely marked and medicines requiring disposal are not segregated from in-date medicines. Fridge temperatures are not routinely recorded. The space for storing completed multi-compartment compliance packs is not adequately managed which creates a significant risk of error.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy mostly identifies and manages the risks associated with its services. It generally completes all the records it needs to by law. And it supports team members to understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. Team members adequately protect people's private information, and they respond appropriately when errors occur. They discuss what happened and they take action to prevent future mistakes. However, the pharmacy's written procedures don't represent all the activities the team members undertake. So, there is a risk they may not conduct these tasks correctly.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) prepared by the pharmacist owner that were reviewed in 2022. These provided the team with information to perform tasks supporting the delivery of services. Team members had read the SOPs and signed and dated the signature sheets to confirm they understood and would follow the SOPs. However, some team members signatures were over five years old which meant there was no evidence they had read and understood the reviewed SOPs. Several key processes did not have an accompanying SOP. These included the handling of controlled drug (CD) prescriptions once the supply had been made to the person. And the dispensing of medicines into multi-compartment compliance packs. This meant there was a risk that team members may not understand or follow correct procedures.

On most occasions when the pharmacist spotted an error during the final check process, they would ask the team member involved to find and correct the error. The pharmacy kept records of these errors, but the entries were made by the pharmacist rather than the team member involved. This meant the team member didn't get the chance to reflect on what caused the error and what they'd learnt from it. A sample of records showed the details captured were limited to the type of error. The sections for recording the cause of the error and the actions to prevent the same error from happening again were not completed. A procedure was in place for managing errors that were identified after the person received their medicines, known as dispensing incidents. This included recording the incident and informing all team members, so they were aware of what had happened. And the actions taken to prevent the error from happening again. Following a dispensing incident that involved the pharmacist dispensing and checking a prescription by themselves, team members were reminded to always involve two of them when dispensing prescriptions. The pharmacy had a template to review near miss errors and dispensing incidents which the Superintendent Pharmacist (SI) completed each month. However, a sample found the details captured from the review were limited to the total number of near miss errors and dispensing incidents. This could mean that the pharmacy team were not able to reflect on any common mistakes. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services, but it didn't provide people with information on how to raise a concern with the pharmacy team. Feedback left by people on social media platforms was reviewed by team members who shared the details with each other.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and CD registers generally met legal requirements. There were a few minor omissions in the RP record, when the RP had failed to sign out. The RP notice was wrong at the start of the inspection but was corrected during the inspection. The pharmacy had a procedure for managing CDs returned by people for destruction but a record of the receipt of the CD and its

destruction was not always made.

The pharmacy had an information governance policy, but this was dated 2016 so it may not contain up-to-date information. And it had not been signed by team members to show they understood the content. Confidentiality agreements were in place for some team members. A college student on work placement for a few weeks was responsible for sending people text messages advising their prescriptions was ready to collect. And entering data on the NHS platform for recording how many times a particular pharmacy service was being used. However, the student had not received any training on how to protect people's confidential information. The team separated confidential waste for shredding on site and off site.

Team members had completed up-to-date safeguarding training appropriate to their role. This included training about the safe space initiative which helps people experiencing domestic abuse. Team members responded well when safeguarding concerns about a vulnerable person were raised.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a team with a good range of skills and experience to safely provide its services. Team members work well together, and they are good at supporting each other in their day-to-day work. They have some opportunities to receive feedback and complete ongoing training to further develop their skills and knowledge.

### Inspector's evidence

The SI worked full-time at the pharmacy with support from regular locum pharmacists. The pharmacy team consisted of a full-time trainee pharmacy technician, two full-time dispensers, two part-time dispensers, one who was an accuracy checker, a part-time pharmacy student and a part-time delivery driver. At the time of the inspection the SI, the two dispensers and the trainee technician were on duty. Along with a temporary delivery driver covering the regular driver and a college student on two weeks work experience. Team members had specific roles, but all were trained on how to undertake key tasks. This ensured the tasks were completed especially at times when team numbers were reduced such as planned and unplanned absence. Team members worked well together and supported each other such as when several people presented at the pharmacy counter at the same time.

Additional training for team members to keep their knowledge up to date was centred around that required for the NHS Pharmacy Quality Scheme (PQS). Team members received informal feedback on their performance and could identify opportunities to progress and develop their skills. One of the full-time dispensers had spoken to the SI about the pharmacy technician training and had been encouraged to enrol when they felt ready to do so.

Team members held regular meetings to discuss matters such as learnings from errors and new procedures. The SI had used a recent meeting to remind team members of the process for handling CD prescriptions once the supply to the person was made. The pharmacy also used an online communication platform to ensure all team members were kept up to date with any changes or new processes.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean, secure and suitable for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

### Inspector's evidence

The pharmacy had relocated from smaller premises to these premises that provided more space in the retail area and the dispensary. The team kept the premises clean and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Heating and lighting were kept to an acceptable level in the dispensary and retail areas. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter.

The dispensary provided sufficient bench space for the team members to work from and they kept the floor spaces clear to reduce the risk of trip hazards. There was a defined professional area and items for sale in this area were healthcare related. The pharmacy had a good sized, soundproof consultation room that the team used for private conversations with people and when providing services. The pharmacy had restricted public access to the dispensary during the opening hours.

## Principle 4 - Services Standards not all met

### Summary findings

The pharmacy provides a range of services that supports local people's health needs. Overall, it manages its services well to help people receive appropriate care. However, the pharmacy does not always store its medicines in an organised and safe manner. The space for storing completed multi-compartment compliance packs is not adequately managed which creates a significant risk of error. Medicines waiting to be disposed of are not always separated from in-date medicines. And fridge temperatures are not routinely recorded.

### Inspector's evidence

People accessed the pharmacy via an automatic door and a ramp leading from the pavement. Team members asked appropriate questions when selling over-the-counter products and knew when to refer to the pharmacist. The pharmacy had an information leaflet for people to read and take away that focused on health matters such as diabetes. The leaflet also contained the contact details of the pharmacy and its opening hours. The NHS Hypertension case finding service was popular. The SI was inviting people who had used the service 12 months ago and had not been diagnosed with hypertension to attend for a follow-up check.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. And to people living in care home settings. Two of the full-time dispensers managed the service but others in the team were trained to provide support when required. A record was kept of each person who received a pack and detailed when their supply was due so the team could prepare the packs in advance. Most of the care home teams were responsible for ordering the prescriptions each month. But they didn't send the pharmacy details of what had been ordered for the team to check that all the medicines had been prescribed. This could make it harder for the pharmacy team members to identify if all the medicines have been correctly prescribed. The pharmacy team ordered the prescriptions for one care home based on the medicines supplied the previous month without contacting the care home team to confirm what was required. This ran the risk that any new medicines or changes to existing medicines since the last supply may be missed. Each person had a record listing their current medication and dose times which the team referred to when dispensing and checking the prescriptions. Most packs were dispensed in advance of the prescription being sent and against the list of medication. An initial check was completed by the pharmacist who referred to the list. The pharmacist completed a second check once the prescription was sent before the packs were bagged ready for supply. The team recorded the descriptions of the products within the packs and but didn't always supply the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs but didn't have all the information about their medicines. The pharmacy received copies of hospital discharge summaries via the NHS communication system which the team checked for changes or new items. And contacted the person's GP to arrange a prescription when required. Completed packs were stored on dedicated shelves and in tote boxes in large piles with no separation between different people's packs. This ran the risk of packs being supplied to the wrong person.

The pharmacy supplied medicine to several people daily as supervised and unsupervised doses. The doses were prepared in advance to reduce the workload pressure of dispensing at the time of supply and were securely stored. However, the prepared doses were not labelled until the day of supply which risked the wrong dose being supplied. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme

(PPP). And the pharmacy had completed an audit as part of PQS to confirm whether anyone prescribed valproate was at risk and provide them with the correct information.

Team members used separate areas in the dispensary for labelling, dispensing, and checking of prescriptions. And they used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Team members initialled dispensed by and checked by boxes on the dispensing labels, to record their actions in the dispensing process. The pharmacy did not have a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal validity. A CD prescription dated in June 2023 had not been marked to indicate it was expired. The pharmacy kept a record of the delivery of medicines to people. And it used CD and fridge stickers on bags and the driver's delivery sheet to remind the team when handing over medication to include these items.

The pharmacy obtained medication from several reputable sources. Many bottles containing medication that had been removed from the original pack were found without a batch number or expiry date on the label. This meant the team could not action any safety alert for the medicine. And did not know whether the medication was in date. On the same day of the inspection the SI sent the inspector a photograph showing these bottles had been removed from the shelves and disposed of. Four tubes of a cream classified as Pharmacy Only (P) medicines were found on open shelves in the retail area. This was highlighted to the SI who was advised to check the medicines in the retail area to ensure there were no other P medicines on the open shelves. The SOPs required team members to check and record fridge temperatures each day. A sample of these records over a 60-day period from June 2023 showed temperatures were not recorded on several days. The records that were made were within the correct range. And on the day of the inspection the fridge temperatures were correct. The pharmacy team checked the expiry dates on stock and usually marked medicines with a short expiry date to prompt them to check the medicine was still in date. A few medicines with short expiry dates were found with no markings, but no out-of-date stock was found. The dates of opening were mostly recorded for medicines with altered shelf-lives after opening. However, opened bottles of methadone oral solution, with limited use once opened, did not have a date of opening recorded. This meant the team wouldn't know if the medicine was still safe to use. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And there were appropriate denaturing kits to destroy CDs. However, some obsolete medicines awaiting destruction were not stored separately to in-date stock. 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 generally uses its facilities to suitably protect people's private information.

### Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. It had the correct equipment available for the services provided and two fridges for holding medicines requiring storage at the correct temperature. The fridges had glass doors that enabled the team to view stock without prolong opening of the door. The SI used information from an NHS list of approved equipment and on a forum for healthcare professionals, the British and Irish Hypertension Society, when purchasing the blood pressure monitor for the Hypertension case finding service.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to help ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they mostly held other confidential information in the dispensary which had restricted public access. However, some documents containing people's confidential information were kept on open shelves in the consultation room where the public could access.

### 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.