General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Leeds Delivery Pharmacy, 56 Harehills Lane, Leeds, West Yorkshire, LS8 4HF

Pharmacy reference: 9011961

Type of pharmacy: Internet / distance selling

Date of inspection: 01/11/2023

Pharmacy context

The pharmacy is in a suburb of Leeds. Its main activities are dispensing NHS prescriptions and delivering medicines to people who live across Leeds and its surrounding areas. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take them properly. People do not visit the pharmacy premises and they access the pharmacy services through its website. People can contact the team by telephone and email.

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
1. Governance	Standards not all met	1.6	Standard not met	The pharmacy keeps incomplete records about the pharmacist who is working at the pharmacy. And this is happening regularly.
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 not all met**

Summary findings

The pharmacy mainly identifies and manages the risks associated with its services. But it does not complete all the records it needs to by law. It has written procedures that the pharmacy team generally follows, and it protects people's private information correctly. Team members respond appropriately when errors occur, they discuss what happened and they take action to prevent future mistakes. But they don't always record their errors so they may miss opportunities to learn and reduce the risks of mistakes happening again.

Inspector's evidence

The pharmacy had a wide range of standard operating procedures (SOPs) developed by the Superintendent Pharmacist (SI). However, there was no date when the SOPs had been produced except for a mention of the date when the pharmacy started operating in November 2022. And there was no review date. The SOPs provided the team with information to perform tasks supporting the delivery of the pharmacy services. Team members had read the SOPs but they had not 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 pharmacy had a procedure for managing errors that occurred during the dispensing process, known as near miss errors. This included the pharmacist discussing the error with the team member involved to identify why it happened and how to prevent it from happening again. The pharmacy had a template to record near miss errors but there was only one entry dated 16 March 2023. So, team members had not always captured the outcome of their discussions with the pharmacist. A separate procedure covered errors that were identified after the person received their medicines, known as dispensing incidents. The pharmacist manager reported there had not been any dispensing incidents since the pharmacy opened. The team had identified medicines that were of higher risk of being picked in error because they looked or their names sounded alike. And team members took steps to reduce the risk by separating the medicines, for example amitriptyline and amlodipine. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And its website provided people with information on how to raise a concern with the pharmacy team.

The pharmacy had current indemnity insurance. A sample of controlled drug (CD) registers met legal requirements, but the pharmacy could do more to check CD stock levels. The Responsible Pharmacist (RP) record had no entries from 26 August 2023 until the day of the inspection, 01 November 2023. And two RP notices were displayed rather than the one showing the RP on duty. The pharmacy's website displayed a privacy notice, details on the confidential data it kept and how it complied with legal requirements. All team members except a new member had up-to-date training on handling confidential information. They separated confidential waste for shredding onsite. But at the time of the inspection the shredder had broken and a small quantity of confidential waste was being stored separately in a box and a basket.

The pharmacy had safeguarding procedures for the team to follow to help protect vulnerable people. And team members completed safeguarding training relevant to their roles. The delivery driver was experienced and knew the information to be shared with the team when they came across potential safeguarding concerns. The pharmacist manager reported concerns to people's GP such as when the

driver could not get an answer from a person who was usually at home.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They complete limited ongoing training and development. So, they may miss the chance to further develop their skills and knowledge

Inspector's evidence

A full-time pharmacist manager and a regular locum pharmacist covered the pharmacy's opening hours. The pharmacy team consisted of an experienced pharmacy technician, a dispenser, a new team member in post two weeks and a delivery driver. A second dispenser had recently been recruited and was due to start in a few weeks.

The delivery driver had many years of experience and had worked for several pharmacies. The new team member was a pharmacist registered overseas who was waiting to enrol onto the GPhC's overseas pharmacist course. The pharmacist manager planned to enrol the new team member onto a dispensing course once their induction period was complete. And to offer them the opportunity to work at another pharmacy that was not closed to the public so they could experience helping people face-to-face. At the time of the inspection all team members except the pharmacy technician were on duty.

Team members worked well together and supported each other. Additional training for the team was limited to regulatory training and learning from errors. They received informal feedback from the pharmacist manager when appropriate and were encouraged to use their experience to suggest changes to processes.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are adequate for the services the pharmacy provides. And they are sufficiently secure.

Inspector's evidence

The premises consisted of one room for dispensing prescriptions including for multi-compartment compliance packs and for storing medicines. The room was untidy with little free space for the team members to work from. Most of the floor was covered with plastic boxes holding stock or completed prescriptions which created a potential trip hazard. A large room to the rear of the premises was being refitted for the team to use when dispensing the compliance packs and for storing completed packs. This would also free up space in the main dispensary. The team kept the pharmacy clean and separate sinks were available for hand washing and preparing medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a small range of services that supports local people's health needs. And it manages its services satisfactorily to help people receive their medicines safely and receive appropriate care. Team members obtain medicines from reputable sources. And they adequately store and carry out checks to ensure medicines are in good condition and appropriate to supply.

Inspector's evidence

The pharmacy was closed to the public which meant people could not directly enter the pharmacy to access its services. Its website provided people with information on the services offered, the contact details of the pharmacy and its opening hours. The pharmacy's landline was connected to the pharmacist manager's mobile number so they could take calls when the main phone line was busy. The pharmacy supported people who could not leave their home and struggled to contact their GP, for example when they had queries about their medication. After receiving a telephone call from people who found themselves in such circumstances the team emailed the surgery to pass on the person's query.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. Team members ordered prescriptions several days before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which was used to check the prescriptions against. Team members added the descriptions of what the medicines looked like to the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The team sent the person's repeat prescription form with the packs so people knew what had been prescribed. The team requested people to use these forms for ordering medicines not supplied in the pack such as liquids. A technical problem at the time of the inspection meant the pharmacy did not directly receive copies of hospital discharge summaries via the NHS communication platform. This had been reported to the relevant NHS team. When notified that a person had been discharged the team contact the person's GP surgery and asked for a copy of the discharge summary. So, they could check for changes or new items.

Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. No-one currently prescribed valproate met the PPP criteria. However, the pharmacist was not aware, until it was discussed, of the new rules requiring valproate to be supplied in the manufacturer's original outer packaging.

The pharmacy provided little space for team members to work separately when performing tasks such as 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. Pharmacy team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy kept a record of the delivery of medicines to people. People did not sign for their deliveries, and this included CDs. Some people requested the medication to be posted through their letterbox. The pharmacy team asked the person to confirm there were no risks associated with this request such as pets or young children at the address. But a record confirming this was not captured for the team to refer to if queries arose. Arrangements were made to support the delivery

of urgent medicines such as antibiotics to people after the driver had finished their shift.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock and recorded medicines that were going out of date over a six-month period. Short-dated stock was not marked to prompt team members to check the medicine was still in date, however no out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. They checked and usually recorded fridge temperatures each day. A sample of completed records found the temperatures were within the correct range. However, on a few days no records had been captured. On the day of the inspection the fridge temperature was within the accepted range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. Appropriate action was taken in response to the alert and all team members informed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And 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 information. And there was equipment available for the services provided. This included a range of CE equipment to accurately measure liquid medication and a fridge for holding medicines requiring storage at these temperatures. The fridge had a glass door that enabled stock to be viewed 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 held private information in the dispensary which had restricted public 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.