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: 29/05/2024

Pharmacy context

The pharmacy is in a suburb of Leeds. Its main activities are dispensing NHS prescriptions and delivering medicines to people who live in 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 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	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 identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows, and it protects people's private information correctly. The pharmacy completes the records it needs to by law. Team members respond appropriately when errors occur, they discuss what happened and they take action to prevent future mistakes

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 and signed the signature sheets to show they understood and would follow the SOPs. They 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. The pharmacy had a template to record near miss errors. And a sample of entries showed detailed information about the error including what had contributed to the error. 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 alike or their names sounded alike. And team members took steps to reduce the risk by separating these medicines. 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 records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The RP clearly displayed their RP notice. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. A few CD registers had the pages stapled together rather than as bounded pages. So, there was a potential risk that these pages and therefore the legal records may be lost.

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 had up-to-date training on handling confidential information. They separated confidential waste for shredding onsite. 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with the appropriate range of experience and skills to provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They are encouraged to make suggestions to ensure the efficient delivery of pharmacy services. Team members receive some feedback on their performance. And they have a few opportunities to complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time locum pharmacist manager and the SI covered the pharmacy's opening hours. The pharmacy team consisted of a part-time pharmacy technician, a full-time dispenser, a part-time dispenser who was completing their three-month probation period, and a delivery driver. The delivery driver had many years of experience and had worked for several pharmacies. At the time of the inspection all team members were on duty. Team members worked well together and supported each other and when required team members from other pharmacies owned by the company worked at the pharmacy.

The pharmacy technician had recently started working at the pharmacy and had several years of experience working in different community pharmacy settings. They were using their previous experience to support the team and to suggest changes to processes. For example, rearranging the storage of medicines to reduce the risk of selecting the wrong medicine when dispensing a prescription. They were also increasing their hours to support the pharmacist manager and team members.

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. The pharmacy had experienced a significant increase in the number of people receiving their medicines in multi-compartment compliance packs. Team members discussed the impact this had on their workload. And agreed to pause the introduction of more people to the service until they had made changes to ensure it remained a safe service. The changes included rearranging the layout of the pharmacy to provide more workspace to dispense the packs. And the additional support from the pharmacy technician as they increased their contracted hours.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally suitable for the services the pharmacy provides. And team members mostly keep floor spaces clear to reduce the risk of trips and falls. They keep the premises appropriately clean, hygienic, and secure.

Inspector's evidence

The premises consisted of one room for dispensing prescriptions including for most of the multi-compartment compliance packs and for storing medicines. Since the last inspection a room to the rear of the premises had been converted to provide some additional space for dispensing and storing the multi-compartments compliance packs. Further work was planned to create more space in this room for the team to work from. Since the last inspection team members had made some progress with tidying the dispensary and creating more space for them to work from. They had also made some improvements on ensuring the floor space was kept clear. However, a few baskets containing prescriptions waiting to be checked by the pharmacist were stored on top of each other on the floor, creating an increased risk of errors. And some plastic boxes containing stock and completed prescriptions were on the floor, which created a potential trip hazard. 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 manages its services well to help people receive appropriate care. It gets its medicines from reputable sources. And team members carry out appropriate checks to make sure medicines are in good condition and suitable to supply. But they do not store all the medicines in an organised manner to help reduce the risk of errors.

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. So, people could communicate with the pharmacy team by telephone and email. The pharmacist regularly contacted people to provide advice about their medication. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer's packs of valproate. And reported that no-one prescribed valproate met the criteria.

The pharmacy provided multi-compartment compliance packs to help many 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 the team referred to during the dispensing and checking of the prescriptions. 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. Team members stored baskets containing the person's prescription and medication list on dedicated shelves that were labelled with the person's name. The completed packs were also stored on these shelves. The pharmacy usually received copies of hospital discharge summaries via the NHS communication platform. So, they could check for changes or new items.

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. Team members contacted people to agree a time window for delivery, for example late afternoon. This information was added to the person's electronic medication record kept at the pharmacy. It was also printed on the name and address label used to seal the medicine bag for the team, including the delivery driver, to refer to. The delivery driver left a note at the person's address when there was no-one to receive the medication. The note asked the person to contact the pharmacy to arrange a further delivery. The team used this opportunity to clarity with the person whether the original agreed time slot was still suitable.

The pharmacy obtained medication from several reputable sources. Most of the medicines stored on the dispensary shelves were stored in a tidy manner. But some of the medicine stock was stored in a disorganised manner on several of the shelves, with an increased risk of selection errors. 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 marked to prompt team members to check the medicine was

still in date when dispensing. 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 recorded fridge temperatures each day and a sample of completed records found the temperatures were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication, along with 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. 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 safe services and it 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. And there was equipment available for the services provided. This included a range of CE marked 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.

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.