General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Advanced Care Pharmacy, Cleckheaton Bus Station, Dewsbury Road, Cleckheaton, West Yorkshire, BD19 5DL

Pharmacy reference: 9012052

Type of pharmacy: Internet / distance selling

Date of inspection: 30/10/2024

Pharmacy context

This pharmacy is located in a bus station in Cleckheaton and provides most of its services at a distance, it has a consultation room which is used to provide some face-to-face services. The pharmacy dispenses NHS prescriptions which are delivered to people. It offers the New Medicine Service (NMS) and the NHS Pharmacy First Service. The pharmacy supplies medicines in multi- compartment compliance packs for some people to help them take their medicines at the right time.

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

Overall, the pharmacy identifies and manages the risks associated with its services to help provide them safely. And people can provide feedback about its services. It keeps the records it needs to keep by law, and these are kept accurate and up to date. And it protects people's personal information appropriately. Team members consistently make records of dispensing mistakes that occur which helps them to learn from them. And they take action to help reduce the chance of similar mistakes from happening again.

Inspector's evidence

Standard operating procedures (SOPs) were available, these had been read and signed by team members. The responsible pharmacist (RP), who was also the superintendent pharmacist (SI) explained that pharmacy students from a nearby School of Pharmacy completed placements at the pharmacy. The students had their own set of SOPs which they read, these were issued by the university and had been reviewed by the SI. Risk assessments had been completed before the pharmacy had opened and were provided after the inspection. The risk assessments covered the services provided, identified the risks and listed the steps that the pharmacy had in place to mitigate these. The risk assessments were due to be reviewed at the end of the year.

Dispensing mistakes which were identified before medicines were supplied to people (near misses) were corrected, discussed with the team member involved in making the mistake and recorded on a log. A separate sheet was used for each week. Near misses were discussed as they occurred with the team and were also reviewed by the SI over a period of time to identify any trends and patterns. Following the review, a meeting was held with the team to discuss the findings and next steps, to ensure mistakes did not reoccur. Where a dispensing mistake had happened, and the medicine had been supplied to a person (dispensing errors), the SI would gather information and investigate what had happened. Dispensing errors were recorded electronically, any locum pharmacists involved were notified, the team were briefed, and steps were taken to avoid the mistake from happening again. Following previous reviews different strengths of Lorazepam had been separated on the shelves and some medicines that ‘looked-alike’ or ‘sounded-alike’ were also separated on the shelves.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and there was information on the website advising people how they could raise concerns or provide feedback, The RP said there had not been any complaints since they had opened but had mostly received questions about deliveries. The team also checked external online reviews for feedback. The A correct RP notice was displayed. When questioned, team members were aware of the activities that could not be carried out in the absence of the RP.

Private prescription records, RP records and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. There had been no emergency supplies made since the pharmacy had opened but the SI was aware of the records that needed to be kept.

The pharmacy had an information governance (IG) policy; all team members had also completed IG training. The pharmacy stored confidential information securely and separated confidential waste

which was then collected by a specialist contractor for disposal.

Team members had all completed safeguarding training and the SI had completed level three training. Team members were aware of the reporting process but would refer any concerns to the RP. Details of the local safeguarding contacts were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. Staff complete ongoing training to help keep their knowledge and skills up to date. Its team members are able to discuss issues as they arise. And the pharmacy does some planning to assess its future staffing needs.

Inspector's evidence

The pharmacy team comprised of the SI who also provided regular pharmacist cover, a trained dispenser, a trainee dispenser and a pharmacy student. The pharmacy also had a delivery driver who was not present at the time of the inspection. Another pharmacist covered one day a week when the SI had a day off. The pharmacy had a partnership with a nearby School of Pharmacy and had students attend for placements. The SI felt that as the business had grown, she felt another team member was needed and the pharmacy was in the process for recruiting either a dispenser or pharmacy technician. Team members appeared to be up to date with their workload.

Staff performance was managed by the SI. Team members were provided with feedback on an ongoing basis and had a one-to-one meeting with the SI on a monthly basis. Team members completing formal training courses were provided with allocated study time. To help make sure team members were up to date, the SI discussed and changes or updates with the team members. Recently the SI had trained team members on medicines relating to Parkinson disease following an incident with Madopar.

The team worked closely together. Any issues team members had or were facing were discussed as they arose or at team meetings. Minutes were recorded for the meetings. Team members felt able to feedback concerns and give suggestions to the RP. Targets were set for the locum pharmacist for the services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and secure. The pharmacy's website gives people information about who is providing its services.

Inspector's evidence

The pharmacy was clean and tidy, and there was ample workspace. Workbenches had been created in a way so that separate areas were used for the different services provided, such as dispensing for care homes, dispensing and managing multi-compartment compliance packs and a separate area for all other dispensing. An allocated checking area was also available. A clean sink was available. Cleaning was carried out by the team members and a contracted cleaner was also used. Medicines were arranged on shelves in a tidy and organised manner. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access.

The consultation room was accessible from the dispensary and also from the main entrance. Services were all provided on an appointment basis.

The pharmacy had its own online website (https://advancedcarepharmacy.co.uk/). The website gave clear information about the pharmacy's opening times, how people could make a complaint, the pharmacy's contact details and details of its owner and the GPhC registration number of the pharmacy and SI. People typically used the website to order their repeat prescriptions and sign-up to use the pharmacy’s services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. Team members take the right action when safety alerts are received, to ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy premises were closed to the public and people were not allowed to visit the pharmacy in person to collect their medicines. But it had a consultation room on site where it provided some face-to-face services. The pharmacy's services were advertised on its website and its social media pages. Team members were aware of the need to signpost people needing services they could not provide and were aware of services available locally or would use the internet to find more information. There was a flat entrance into the consultation room and the pharmacy was easily accessible to people using mobility aids and pushchairs. Services were all provided on an appointment basis and the pharmacy had a good working relationship with local surgeries who referred people for services such as NHS Pharmacy First and contraception. The SI was an advanced clinical practitioner but did not provide any prescribing services from the pharmacy at the time of the inspection.

There was an established workflow within the dispensary and prescriptions were assembled by the dispensers and checked by the RP. 'Dispensed-by' and 'checked-by' boxes were available on dispensing labels, and these were routinely signed to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, to prevent them being mixed up. Baskets were also colour-coded to help manage the workflow.

The pharmacy also supplied medicines to people residing in a nursing home. Prescriptions were ordered by the nursing home team who emailed a list of all the medicines they had ordered for each person to the pharmacy. Once prescriptions were received any missing items were highlighted and the nursing home was notified. Medicines administration record charts (MAR) were supplied when medicines were delivered. Acute medicines were also supplied to the nursing home. The pharmacy was notified by email and arranged for delivery on the same day if stock was available. As the pharmacy was not open at the weekends the nursing home used different pharmacies but had an agreement with the SI to notify her so that she could check an ensure there were no issues with nominations.

Some people's medicines were supplied in multi-compartment compliance packs. They were prepared by the dispensers. A laminated sheet with the steps to follow when preparing the compliance packs was displayed in the dispensary. Prescriptions were ordered by the pharmacy. Once prescriptions were received, they were checked for any changes and missing medicines. Medicines were checked by the RP before packs were assembled and rechecked once completed. If people were admitted into hospital information was received electronically as part of the discharge medicines service. Some people had complex medical needs and their medicines changed often, the SI personally dealt with these prescription requests and checks. Assembled compliance packs were labelled with product descriptions and mandatory warnings. Patient information leaflets were issued monthly.

The pharmacy's team members were aware of the risks associated with the use of valproate containing medicines during pregnancy. Additional checks were carried out when people were supplied with

medicines which required ongoing monitoring. Signed and in date patient group directions (PGD) were available for the services provided.

Deliveries were carried out by the designated delivery driver or in some cases by team members. The driver had completed training. Signatures were obtained for some medicines delivered including CDs. If people were not available to accept the delivery the medicines were returned to the pharmacy. The pharmacy team sent people a text message in the morning on the day their medicines were due to be delivered which asked people to notify the team if they were not due to be in. Some NHS prescriptions were received from people residing nationwide. These medicines were sent out using a Royal Mail tracked delivery service. The pharmacy had a process for dealing with failed deliveries.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of medicines. And CDs were kept securely. Expiry dates were checked routinely, and short-dated stock was marked with stickers. A random sample of stock was checked, and no expired medicines were found. Out-of-date and other waste medicines were separated and collected by licensed waste collectors. Drug recalls were received by email, these were printed, shared with the team, actioned and filed. The SI also kept a record of all actioned alerts on a spreadsheet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it keeps them secure to help protect people’s data.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. A medical fridge was available. Up-to-date reference sources were available including access to the internet. The pharmacy had a blood pressure monitor, thermometer, ambulatory blood pressure monitor, otoscope, pulse oximeter and blood glucose monitor which was used as part of the services provided. The SI was aware of the need for calibration. The pharmacy's computers were password protected and screens were not visible to people using the pharmacy.

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.