General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Care Pharmacy, Unit 14, Unity Business Centre, 26 Roundhay Road, Leeds, West Yorkshire, LS7 1AB

Pharmacy reference: 9012058

Type of pharmacy: Internet / distance selling

Date of inspection: 11/04/2024

Pharmacy context

The pharmacy is in a business park close to Leeds City Centre. People access the pharmacy's services through its website and visit in person for pre-arranged appointments only. People can contact the team by telephone and email. The pharmacy dispenses NHS prescriptions and it supplies some medicines in multi-compartment compliance packs to help several people take their medication properly. And it delivers medicines to people's homes. The pharmacy offers several private services including a travel clinic, where it provides travel advice and the administration of vaccines. It also provides a private COVID-19 vaccination service and an ear wax removal service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 mainly identifies and manages the risks associated with its services. It has written procedures that the pharmacy team generally follows to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. Team members suitably protect people's confidential information, and they clearly understand their role to help protect vulnerable people. 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 from their mistakes and reduce the risks of mistakes happening again.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. These provided the team with information to perform tasks supporting the delivery of the pharmacy's services. Team members accessed the SOPs using personal log-in details. And completed a quiz connected to each SOP to show they had read, understood and would follow the SOP. The pharmacists had access to the team's accounts so they could monitor each team member's progress in completing them. The pharmacy had completed risk assessments covering the provision of its private services. These identified key risks to the safe delivery of these services and the actions the pharmacy would take to mitigate these risks. For example, the risk of the person's GP not being updated with details of the travel vaccines administered was mitigated by providing the person with the vaccination record. And emailing the record to the person's GP. The team members had a good understanding of the different services provided by the pharmacy. And they demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a SOP covering the management of errors that were identified at the final check of a prescription. The SOP included keeping a record of the error but this was not being followed by the team. The pharmacist discussed the error with the team member involved to identify any learning opportunities but a record of the error was not made. Team members had separated some medicines with similar names to reduce the risk of picking the wrong one when dispensing a prescription. The pharmacy had a procedure for managing errors that reached the person after their prescription had been dispensed, known as dispensing incidents. The team reported there had not been any dispensing incidents in several months. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the pharmacy's website provided people with details on how to raise a concern. Team members monitored feedback given by people using online platforms and responded to the person when concerns about the pharmacy's services were raised. This included when a person had raised a concern regarding the time of day their medication was delivered to them.

The pharmacy had current indemnity insurance. A sample of records required by law including the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. A random balance check undertaken during the inspection was correct. The travel clinic service and the COVID-19 vaccination service were supported by up-to-date patient group directions (PGDs) supplied by a specialist company. These gave the pharmacists the legal authority to administer the vaccines. The PGD's were stored electronically which the pharmacists accessed through personal log-in numbers. And they completed a form connected to each PGD to show they had read them, understood them and would follow them.

The pharmacy's website displayed details on the confidential data it kept and how it complied with legal requirements. It also displayed a privacy notice. Team members had received training on how to correctly manage confidential information. And they used a labelled container to hold confidential waste that was transferred into dedicated bags and regularly removed for shredding offsite. The pharmacy had safeguarding procedures and guidance for the team to follow to help protect vulnerable people. And team members had completed training relevant to their roles. Team members took appropriate action when safeguarding concerns arose. The pharmacy apprentice was also the delivery driver and reported concerns back to the team who took appropriate action such as contacting the person's GP.

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 have opportunities to complete training and are supported to take on new roles so they can suitably develop their skills and knowledge.

Inspector's evidence

The Superintendent Pharmacist (SI) and regular locum pharmacists covered the opening hours. The pharmacists were supported by a part-time dispenser and a full-time pharmacy apprentice who was also the pharmacy's delivery driver. At the time of the inspection one of the regular locum pharmacists, the dispenser and pharmacy apprentice were on duty. The pharmacy apprentice had protected time at work to complete their training modules. And they received support from the other team members.

The pharmacy regularly held team meetings and team members could suggest changes to processes or new ideas of working. For example, the dispenser had introduced a system of listing people due for a COVID-19 vaccination. And regularly checking the stock levels of the vaccines so the vaccination was available when the person presented for their appointment.

The pharmacy had recruited the dispenser in February 2024 as the team's workload increased. The dispenser had previously worked in community pharmacies that didn't provide private services such as the pharmacy's travel clinic. So, their induction programme included time with the pharmacists to learn about the private services alongside reading the SOPs and other documents that supported the services. This included a flowchart that the dispenser could refer to when a person telephoned the pharmacy asking about the travel clinic service. The dispenser demonstrated a good knowledge of the different travel vaccinations including how many vaccines were needed to complete the course. And how far in advance of travel the vaccines should be administered to ensure the person had appropriate cover. The dispenser was also good at reassuring people who reported they were nervous about needles. The pharmacists had completed training provided by the company that supplied the equipment for the ear wax removal service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic, and kept secure. The pharmacy's website is clearly laid out and professional in appearance which helps ensure people accessing its services receive appropriate care.

Inspector's evidence

The pharmacy team kept the premises clean and tidy. There were separate sinks for the preparation of medicines and hand washing and these were kept clean. Alcohol gel was also available for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards and there was enough storage space for stock, assembled medicines and medical devices. The pharmacy had a large consultation room that was used for services such as the travel clinic. The room was professional in appearance and well equipped. The pharmacy had restricted public access during its opening hours and was kept secure when it was closed.

People accessed the pharmacy's services through its website which was professional in appearance and straightforward to use. People were provided with clear information on how to access the service and could view details of the SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which help people to meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply. However, the team has not fully assessed the risks associated with providing valproate medicines outside of the manufacturer's original packaging.

Inspector's evidence

The pharmacy was generally closed to the public which meant people could not directly enter the pharmacy unless an appointment had been made for one of the private services. The pharmacy's website provided people with information on the services offered and the contact details of the pharmacy. So, people could communicate with the pharmacy team by telephone and email.

People were offered an appointment for the COVID-19 vaccination once the vaccines order had arrived from the wholesaler. This ensured people were not presenting at the pharmacy when there was no vaccine stock available. The team kept a list of people who had contacted the pharmacy to arrange an appointment. And used the same list to track when an appointment had been made and when the person had received the vaccine. People were given the manufacturer's packaging leaflet, so they had up-to-date information about the vaccine.

The ear wax removal service was popular. Details of the consultation were recorded on a secure electronic platform and they were sent to the person's GP so their medical records could be updated. The pharmacists could contact an ear, nose and throat specialist for help with any queries such as a person presenting who may have an ear infection, which meant they could not have the procedure. In such circumstances, and if appropriate, the person was referred to their GP for antibiotics.

In addition to the PGDs the pharmacy travel clinic was provided in accordance with guidance issued by the National Travel Health Network and Centre. People contacted the pharmacy by telephone or email to initially discuss their travel plans. The dispenser supported the travel clinic by completing the initial questionnaire with the person by gathering details of their travel arrangements and providing general advice on the service. A pharmacist assessed this questionnaire then contacted the person to ask about their medical history and prescribed medicines. They then discussed the vaccines the person would require. They accessed the person's NHS Summary Care Records, with their permission, to confirm their medical information and to ensure the vaccine was safe to administer. This ensured the service was suitable to meet the person's healthcare needs before an appointment at the pharmacy was arranged. People were provided with information about the vaccination for them to take away and read. And they were given a record detailing the vaccines they had received. The person's GP was also informed of the vaccines the person had received so their medical records could be updated. The pharmacists had easy access to adrenaline injections in the event of a person having an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. To manage the workload the team ordered prescriptions one week 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 team members referred to during the dispensing and checking of the prescriptions. The team recorded the descriptions of the products within the packs but did not supply

the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs but did not have all the information about their medicines.

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) including the requirement to supply original manufacturer's packs of valproate. And they reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. The team reported no-one currently prescribed valproate met the PPP criteria. But one person who had their medication in compliance packs also had their valproate dispensed into the packs. This had been agreed with the person's GP. But the pharmacy had not completed a risk assessment to ensure the supply was issued safely and the person was aware of the risks associated with valproate medications.

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. The team used the pharmacy's electronic patient medication record system to record who in the team had dispensed and checked the prescription. The pharmacy used an online platform to record the deliveries due each day for the pharmacy apprentice to plan their delivery route. Deliveries were generally arranged later in the day when other tasks the pharmacy apprentice was involved with were completed. However, arrangements would be made to ensure people received any urgent supplies of their medication on time. The online platform enabled team members to track the deliveries and check when the person had received their medication. The team contacted the person before their delivery was due to confirm they'd be at home to accept the delivery. If the person was not at home a note was left informing the person of this and asking them to contact the pharmacy to arrange another delivery.

The pharmacy obtained medication from several reputable sources and team members followed procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were marked to prompt the team to check the medicine was still in date. No out-of-date stock was found. Team members checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. And they kept CDs securely stored. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. The team received alerts and recalls about medicines and medical devices via an email and took appropriate action according to the instructions on the alert.

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. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And two fridges for holding medicines requiring storage at this temperature. Technical support was provided by the company supplying the equipment for the ear wax removal 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 ensure their conversations with people were held in private.

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.