General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Pharmacy Leeds, 7A Stainburn Parade, Stainburn Drive, Leeds, West Yorkshire, LS17 6NA

Pharmacy reference: 9012255

Type of pharmacy: Internet / distance selling

Date of inspection: 15/10/2024

Pharmacy context

This pharmacy is in a suburb of Leeds. People do not visit the pharmacy premises, but they can access its services via its website. And they can contact the team by telephone and email. The pharmacy's main activities are dispensing NHS prescriptions and delivering medicines to people's homes. The pharmacy provides multi-compartment compliance packs to help several people take their medicines.

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 team members suitably identify and manage the risks associated with the services provided by the pharmacy. They follow written procedures to help them perform tasks safely. And they know how to respond appropriately when errors occur. Team members identify potential risks to the safe dispensing of prescriptions, and they take action to prevent mistakes. The pharmacy protects people's private information, and it mostly completes the records it needs to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) which provided the team, which solely consisted of the three pharmacist owners, with information to perform tasks supporting the delivery of its services. There was no specific start date for the SOPs but there was reference to them being completed prior to the pharmacy opening which was January 2024. There also wasn't a date when they would be reviewed to ensure they were still relevant to the services provided. The pharmacists had read the SOPs but no records were kept to show this.

The pharmacy had a procedure for identifying and recording errors made during the dispensing of a prescription, known as near miss errors. The pharmacy's electronic patient medication record (PMR) system which used bar code scanning technology captured near miss errors. However, the records were not available to view at the time of the inspection. A separate procedure covered errors that were identified after the person received their medicines, known as dispensing incidents. The pharmacists reported there had not been any dispensing incidents since the pharmacy opened. And explained most of the prescriptions were dispensed as repeat prescriptions which were dispensed ahead of the person needing their medication. So, the pharmacists felt they had time to dispense the prescriptions and focus to help reduce the risk of errors. They separated the different stages of dispensing the prescriptions between them so the pharmacist completing the final check was not involved in the dispensing of the prescription. The PMR scanning technology alerted the pharmacists when the wrong medication had been selected. And the pharmacist dispensing controlled drugs, fridge lines and quantities less than the manufacturer's original pack asked one of the other pharmacists to check what had been dispensed before the final accuracy check took place. The pharmacists had separated omeprazole capsules and tablets after identifying the wrong formulation was sometimes picked in error.

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 pharmacists monitored feedback posted on social media platforms by people who had used the pharmacy's services so they could appropriately respond.

The pharmacy had current indemnity insurance. A sample of records required by law mostly legal requirements. The Responsible Pharmacist (RP) record was correct but the RP notice was not on display, this was corrected during the inspection. Some of the controlled drug (CD) registers did not have the heading completed. The pharmacy's website displayed a privacy notice, details on the confidential data it kept and how it complied with legal requirements. The pharmacists separated confidential waste and they shredded it onsite. The pharmacy had safeguarding procedures for the pharmacists to follow to help protect vulnerable people. And they had completed relevant safeguarding

training. The pharmacists delivered people's medicines which helped them identify any potential safeguarding concerns and take appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team with a range of experience and skills to provide its services. Team members work well together and use their knowledge and skills to introduce new ways of working to support the safe delivery of the pharmacy's services.

Inspector's evidence

The three pharmacist owners including the Superintendent Pharmacist (SI) worked full time at the pharmacy, there were no other team members. The pharmacists worked well together especially as the number of prescriptions dispensed had increased in recent months. They used their experience from working at other pharmacies to introduce processes to support the safe delivery of the pharmacy's services. For example, they introduced an audit trail to capture when each stage of the dispensing of prescriptions for the multi-compartment compliance packs was completed. So, they could identify any issues such as missing prescriptions. The pharmacists used an online communication platform to share key pieces of non-confidential information.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic, and 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 pharmacists kept the pharmacy premises clean and tidy. There were separate sinks for the preparation of medicines and hand washing and these were kept clean. The pharmacy provided plenty of dispensing benches for the pharmacists to work from and there was enough storage space for stock, assembled medicines and medical devices. The pharmacy had restricted public access 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 pharmacy's services and could view details of the SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a small range of services to support people's health needs. It obtains medicines from reputable sources, and the team adequately stores and carries out checks on medicines to ensure they are in good condition and appropriate to supply. Team members generally manage the pharmacy services safely and effectively to help make sure people receive medicines when they need them. However, the team has not fully assessed the risks associated with providing some medicines outside of the manufacturer's original packaging.

Inspector's evidence

The pharmacy was closed to the public which meant people could not directly enter the pharmacy premises 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 pharmacy provided multi-compartment compliance packs to help several people take their medicines. The pharmacists kept a list of people who received the packs and when they were due to be supplied. And they recorded when each stage of ordering the prescriptions and dispensing the medication was completed. Prescriptions were issued as electronic repeat dispensing and dispensing took place several days before supply. So, there was time to manage issues such as medicine stock shortages. Some supplies were made to people living in assistant living accommodation. The teams at the assisted living accommodation ordered the prescriptions for medicines not supplied in the packs on behalf of the person. And sent the pharmacy details of the medicines ordered for the team to check the prescription against. Each person had a record listing their current medication and dose times which was referred to during the dispensing and checking of the prescriptions. The descriptions of what the medicines looked like were added to the packs and the manufacturer's patient information leaflets were supplied to people. This meant people could identify the medicines in the packs and had the information they needed about their medicines. The pharmacy occasionally received copies of hospital discharge summaries via the NHS communication platform. So, the pharmacists could check for changes or new items.

The pharmacists were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP), and they reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. The team reported that no-one prescribed valproate met the criteria. They were aware of the requirement to supply original packs of valproate. But reported one person who had their medication in multi-compartment compliance packs also had their prescribed valproate in the packs. The pharmacists 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. This was discussed with the pharmacists who agreed to complete a risk assessment.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's prescriptions and medicines and to help prevent them becoming mixed up. The pharmacists had unique log-in numbers to access the PMR which provided an electronic audit trail showing which pharmacist had dispensed and checked the prescription. When the pharmacy didn't have enough stock of someone's medicine, it provided a

printed slip detailing the owed item. The pharmacists delivered medicines to people's homes, there was no delivery driver. This enabled the pharmacists to provide people with advice about their medicines. Team members agreed a day and time with people for their regular deliveries. When the person hadn't had their medicines delivered before or for one-off deliveries team members contacted the person before the delivery to confirm they would be at home. The PMR recorded people due to have their medicines delivered each day. But no record was kept when the supply was made for the team to refer to if queries arose. The pharmacy occasionally used a courier service that tracked the delivery of medicines to people who lived outside of the Leeds area. Following an incident when the supply was left on the person's doorstop which meant there was no signature to show receipt of the medication, the pharmacists reported this to the couriers' management team. And introduced a system to clearly mark the parcel containing the medication to remind the person making the delivery that a signature was required. The pharmacists reported that had not been any other incident since this was introduced.

The pharmacy obtained its medication from recognised sources. The pharmacists kept the medicines tidily on the shelves and they kept CDs securely stored. They checked the expiry dates of medicine stock on receipt from the wholesalers, and the PMR checked the expiry date when the medicine was scanned. The pharmacists didn't mark medicines with a short expiry date to prompt them to check the medicine was still in date. However, no out-of-date stock was found. Team members checked and recorded fridge temperatures each day. A sample of these records found several had a maximum reading outside the correct range for example 8.5 degrees Celsius. A reading taken during the inspection was correct. The pharmacists discussed installing a temperature probe inside the fridge that would provide regular readings throughout the day. 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 pharmacists with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE marked equipment to accurately measure liquid medication. And a fridge for medicines requiring storage at these temperatures. The pharmacy computers were password protected and access to people’s records restricted by the NHS smart card system. The pharmacy held other private information securely and 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.