General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: K & M Pharmacy Ltd., 325 Meltham Road, Netherton, HUDDERSFIELD, West Yorkshire, HD4 7EX

Pharmacy reference: 1039614

Type of pharmacy: Community

Date of inspection: 28/02/2020

Pharmacy context

The pharmacy is adjacent to a health centre in Netherton. Pharmacy team members dispense NHS and private prescriptions. And they sell a range of over-the-counter medicines. The pharmacy offers services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). Pharmacy team members supply medicines to people in multi-compartment compliance packs. And they deliver medicines to people's homes.

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 has procedures to identify and manage risks to its services. And pharmacy team members follow the pharmacy's written procedures to complete the required tasks. The pharmacy protects people's confidential information. And it keeps the records it must by law. Pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. They discuss and record mistakes that happen when dispensing. And other risks identified around the pharmacy. But they don't regularly record details of why these mistakes happen. And they don't always establish whether their changes have been effective. So, they may miss some opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in January 2018. And the next review was scheduled for January 2020. The pharmacist was currently reviewing the procedures. And the process had been delayed because of staff shortages. Pharmacy team members had read and signed the SOPs in 2018 and 2019. The pharmacy defined the roles of the pharmacy team members in each procedure. The pharmacist had completed a risk review in January 2019. During the review, he had identified and considered several key risks in the pharmacy. For example, the risk of errors with common look-alike and sound-alike (LASA) medicines, the cluttered stock room and the risk of medicines being stolen from the delivery vehicle. Pharmacy team members had discussed the risks identified. And they had made changes to try and mitigate these risks. For example, they had separated key LASA medicines on the shelves to help prevent picking errors while they were dispensing. They had tidied and reorganised the stock room. And the delivery driver had improved his awareness of security risks, making sure his vehicle was always locked and that totes containing prescriptions bags were covered from view. The pharmacist was due to revisit the review in February 2020 to establish the outcomes of the changes made.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. They usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time. Pharmacy team members gave some examples of separating common look-alike and sound-alike (LASA) medicines after mistakes had been made. For example, they had separated amitriptyline and atenolol to prevent picking errors. The pharmacist analysed the data collected about mistakes every month. But he did not record his analysis. And pharmacy team members did not reflect on the changes they had made previously to see if they had reduced the risks identified. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It had a documented procedure for pharmacy team members to follow. And this gave details about the level of investigation and the records that were required for each error. The procedure did not give details about how the errors should be recorded. The pharmacist recorded dispensing errors on the person's electronic medication record. This relied on the pharmacist remembering the names of people who had been involved in dispensing errors. And this made records difficult to retrieve. Some examples of records were seen. And they included information about what had happened. They did not record much detail about why the mistakes had happened. Or what the pharmacy had done to help reduce the risks of the mistake happening again. This was discussed. And pharmacy team members explained a

recent error where someone had received an incomplete pack of medicines. They had discussed the error. And were making more effort to make sure that split packs of medicines were marked on all sides of the pack. The documented procedure was discussed with the pharmacist. And he gave an assurance that he would improve the system for recording dispensing errors during the current review of the pharmacy's procedures.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. One example of feedback from people was the pharmacy having somewhere to talk to pharmacy team members privately. In response, the pharmacy had installed a consultation room in the retail area. And this provided a confidential space for people to talk to team members.

The pharmacy had up-to-date professional indemnity insurance in place. They had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity after each entry was made in the registers. The pharmacist explained that CDs not used frequently were audited every month. But he did not record these checks. The pharmacy kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. Pharmacy team members had trained to protect privacy and confidentiality in 2018 and 2019 by completing a training pack. And by completing a multiple-choice assessment. The pharmacist marked the assessments. And he discussed any incorrect answers with pharmacy team members. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR).

The pharmacy had an SOP available to instruct pharmacy team members about what to do in the event of a safeguarding concern. And this contained up-to-date contact information for local safeguarding teams. All pharmacy team members had completed training on safeguarding in 2020. Pharmacy team members explained clearly what they would do if they had a safeguarding concern. The pharmacist said he would discuss his concerns with local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They regularly complete training. And they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable making suggestions to help improve pharmacy services. Their suggestions are considered. And changes are made to help improve the way the pharmacy delivers its services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, a dispenser and a trainee dispenser. Pharmacy team members completed online training modules at least once a month. And pharmacy team members were provided with time at work to complete their training. The training modules covered a wide variety of topics. Recent examples included training about sepsis, alcohol awareness, safeguarding and antimicrobial resistance. Pharmacy team members also had regular discussions informally during quieter periods. Pharmacy team members received an appraisal with the pharmacist every year. They discussed their performance. And any learning needs they had. They set objectives to address any learning needs identified. One recent example was for the trainee to complete her dispenser training course. Pharmacy team members were supported to learn by the pharmacist. And he provided regular teaching and signposting to relevant resources.

The dispenser explained that she would raise professional concerns with the pharmacist owner, superintendent pharmacist (SI) or regular locum pharmacist. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And pharmacy team members were aware of the procedure.

Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, their process for checking the expiry dates of medicines did not include highlighting packs of medicines that were short dated. Instead, short-dated items were documented on a list for removal the month before they expired. The discussed this. And identified a risk that someone may not notice an item was short dated and dispense it by mistake. So, they had changed their process to include clearly highlighting packs of medicines that were short-dated to help reduce the risks of medicines being dispensed that were not fit for purpose. The pharmacy owners did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and properly maintained. It provides a suitable space for the services provided. The pharmacy has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. It was tidy and well organised. And pharmacy team members kept floors and passage ways free from clutter and obstruction. The pharmacy had a safe and effective workflow in operation, with clearly defined dispensing and checking areas. Pharmacy team members kept equipment and stock on shelves throughout the premises. The pharmacy also had a room on the first floor for storage. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people.

The pharmacy had a clean, well maintained sink in the dispensary which pharmacy team members used for medicines preparation. It had a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy were maintained to acceptable levels. The pharmacy's overall appearance was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. The pharmacy has systems in place to help provide its services safely and effectively. It sources its medicines safely. And it stores and manages its medicines properly. Pharmacy team members take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely. They dispense medicines into devices to help people remember to take them correctly. And pharmacy team members generally manage this service well. But they don't always regularly supply these people with written information to help them use their medicines effectively.

Inspector's evidence

The pharmacy had level access from the street. It advertised services in various places in the retail area. And displayed its opening times to people outside the pharmacy. Pharmacy team members explained they could provide large-print labels to help people with a visual impairment. And they would use written communication to help someone with a hearing impairment. Some pharmacy team members spoke Urdu and Punjabi, as well as English. And this helped them to communicate with most people in the local community.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. He checked if the person was aware of the risks if they became pregnant while taking the medicine. And checked if they were on a pregnancy prevention programme. He referred people to their GP if he had any issues or concerns. The pharmacy had a stock of printed information material to give to people to help them manage the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. The pharmacy attached backing sheets to the packs, so people had written instructions of how to take their medicines. And pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. They regularly provided people who received their packs monthly with patient information leaflets about their medicines. But they did not routinely provide people with leaflets if they received their packs weekly. This was discussed. And the pharmacist gave an assurance that everyone receiving their medicines in packs would be provided with the necessary leaflets regularly. Pharmacy team members documented any changes to medicines provided in packs on the patient's electronic medication record. The pharmacy delivered medicines to people's homes. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The team highlighted bags containing controlled drugs (CDs) with a sticker on the bag and on the driver's delivery sheet. And people signed for CDs on a separate delivery docket.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines tidily on shelves. And it kept all stock in restricted areas of the premises where necessary. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training. The pharmacy had the necessary equipment in place. And pharmacy team members scanned each compliant medicine pack during dispensing to check for falsified medicines. And to decommission the product from the supply chain. The pharmacy had not updated its documented procedures to

incorporate the necessary checks in to the dispensing process. The pharmacist said this would be done during the current review of the pharmacy's standard operating procedures (SOPs). The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a coloured sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during the month before their expiry. The pharmacy responded to drug alerts and recalls. And pharmacy team members quarantined and affected stock found for destruction or return to the wholesaler. They recorded any action taken. And their records included details of any affected products removed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. The pharmacy positioned computer terminals away from public view. And these were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The pharmacy had a dispensary fridge, which was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment, and they stored all items securely.

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.