General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hussain Dispensing Chemist; B., 141 North Street, KEIGHLEY, West Yorkshire, BD21 3AU

Pharmacy reference: 1039656

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

The pharmacy is in a parade of shops in the suburbs of Keighley. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption. They provide seasonal flu vaccinations and meningitis vaccinations for Hajj and Umrah pilgrimages. And, pharmacy team members provide medicines to people in multi-compartmental compliance packs.

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 has procedures to identify and manage risks to its services. And pharmacy team members follow them 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 safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen when dispensing. But, they don't always discuss or record much detail about the causes of mistakes. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had recently consolidated with another of the company's local pharmacies. The nearby premises had been closed and all business had been transferred to the pharmacy. The pharmacist explained that their workload had increased by approximately 50%. And, to manage the increased workload, a full-time dispenser and an apprentice dispenser had relocated to the pharmacy. And, an additional pharmacist was working flexible hours to help the pharmacy manage the increase in the number of multi-compartmental compliance packs being dispensed. The pharmacy had also converted a second-floor storage room in to a dispensary for the preparation, management and storage of packs.

The pharmacy had a set of standard operating procedures (SOPs) in place. And the pharmacist reviewed them regularly. The sample checked were last reviewed in October 2018. And the next review was scheduled for October 2020. The pharmacist explained that because of the recent merger, they would most likely review the SOPs sooner than 2020 to reflect any changes made to accommodate the increased workload. Pharmacy team members had read and signed the SOPs since they were last reviewed. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. But, they did not discuss 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. The pharmacist analysed the data collected about mistakes every two to three months. And, they looked for patterns of different types of error or medicines involved. They did not analyse the data for patterns of causes. But, pharmacy team members had made some changes to help prevent mistakes happening again. For example, they attached alert stickers to shelves in front of look-alike and sound-alike (LASA) medicines that had been involved in an error. And, they highlighted medicines that had been identified nationally as LASA medicines. Pharmacy team members had also separated some of these medicines on the shelves. But, over time, some of the medicines had been placed together again and the separation had been lost. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents using template reporting forms. The pharmacy had two dispensing error records available. And, both had been made in 2019. There were no records available of errors before 2019. The pharmacist said they had started working at the pharmacy in January 2019 and did not know if any errors had been made before that. The records available gave details of the error that had happened. And, they gave some brief details about the causes of the error and the actions taken to prevent a recurrence. The pharmacist also reported dispensing errors to the NHS National Reporting and Learning System (NRLS).

Up-to-date patient group direction (PGD) documents and SOPs were available for the vaccination services being provided. And, the pharmacist had declarations of competence and training to provide the services safely. The pharmacist said she had completed a checklist before providing the meningitis vaccination service. And, this was to assess whether the pharmacy's consultation room was suitable to provide these vaccinations and that the right equipment was available. But, she did not document the assessment. And, she had not carried out a risk assessment before providing the flu vaccination service.

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 received from people was about having somewhere to speak to pharmacy team members privately. So, the pharmacy had recently installed a consultation room, to help facilitate private discussions and to provide services from.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And, pharmacy team members audited the registers against the physical stock quantity approximately each month. The pharmacy kept methadone registers electronically. But, pharmacy team members did not audit methadone running balances as frequently. For example, the last audit of the sugar free methadone register took place on the 15 August 2019. This was discussed. And the pharmacist appreciated that it would be easier to deal with any discrepancies identified if balances were audited more frequently. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. It maintained a responsible pharmacist record on paper. And the record 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.

The pharmacy kept sensitive information and materials in restricted areas. Pharmacy team members shredded confidential waste. They had been trained to protect privacy and confidentiality. The pharmacist had delivered the training verbally. And, pharmacy team members said they had completed a workbook about the General Data Protection Regulations (GDPR). The pharmacy did not have any records of the training completed. But, 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).

Pharmacy team members were asked about safeguarding. A dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. But, some pharmacy team members were less sure. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. And, it had a procedure available to help pharmacy team members deal with a concern. All pharmacy team members had completed training in 2018.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. Pharmacy team members complete ad-hoc training. And, they learn from the pharmacist and each other to keep their knowledge and skills up to date. Pharmacy team members feel comfortable discussing issues and act on ideas to support the effective delivery of services. They reflect on their own performance.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two pharmacists, two dispensers, an apprentice dispenser and a delivery driver. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacists about current topics. Pharmacy team members received an appraisal each year. They discussed areas of good performance. And, set objectives to address any learning needs identified. One example of a recent objective was for a dispenser to enrol in training to become a pharmacy technician. He said he was still in the process of discussing the course with the pharmacy owner.

A dispenser explained how they would raise professional concerns with the pharmacists or superintendent pharmacist (SI). They felt comfortable raising a concern. And confident their concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. And pharmacy team members were unsure about how to raise a concern outside of the organisation. Pharmacy team members communicated with an open working dialogue during the inspection. They described a change they made after identifying an area of improvement. They had previously kept records of deliveries made on paper. But, this had been difficult to manage. And, pharmacy team members had found it difficult to track which deliveries the driver had with them. So, they had implemented an electronic system to manage delivery records. And, an electronic device for the driver to use to record deliveries and obtain signatures from people to confirm they had received their medicines. The pharmacy owners and SI did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well maintained. It had a small amount of bench space available in the ground floor dispensary for the volume of dispensing being carried out. But, pharmacy team members generally kept the pharmacy tidy and well organised. And, multi compartmental compliance packs were prepared in another dispensary on the second floor, which had enough bench space available. The floors and passage ways were generally free from clutter and obstruction. But, some corridors were cluttered with boxes of stock. There was a safe and effective workflow in operation in each area where medicines were prepared. And, each had clearly defined dispensing and checking areas. The pharmacy kept most equipment and stock on shelves throughout the premises. And, the pharmacy had enough room for storage.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises 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 is generally accessible to people. It manages its services well to provide safe and effective care. And, pharmacy team members use the available technology to help reduce risks and provide an efficient medicine's delivery service to people. The pharmacy sources, stores and manages its medicines appropriately. But, the team members don't always keep records of when they check the expiry dates of medicines. So, they can't evidence that all medicines are checked regularly and are in date.

Inspector's evidence

The pharmacy was accessed via several steps from the street. There was no ramp available to facilitate wheelchair or buggy access to the premises. The pharmacist said that there were plans to refurbish and refit the pharmacy. And, part of the plan was to install a ramp in the front yard of the pharmacy. She said that people were aware that the pharmacy could deliver, and they would ring if they needed help. Pharmacy team members used written communication with people with hearing impairment. And they could produce large print labels for people with visual impairment. Pharmacy team members were able to speak Urdu and Punjabi, as well as English. And, they said this served most of their patients that could not speak English. A dispenser also said he would use Google Translate as a last resort to help communicate with anyone who didn't speak these languages. One example was a small number of eastern European people in the local community. The pharmacy had 'Patient Self-Care' fact sheets available at the pharmacy counter. Pharmacy team members explained they used the sheets to give people information about various health conditions or to help them take their medicines safely. Examples of the sheets available included information about asthma, pain management and advice for people taking oral anticoagulants.

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. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines in multi-compartmental compliance packs when requested to care homes and to people in their own home. For people living in their own home, it attached backing sheets to each pack, so people had written instructions of how to take the medicines. Pharmacy team members included the descriptions of what the medicines looked like, so they could be identified in the pack. And, they provided people with patient information leaflets about their medicines each month. The care homes that the pharmacy provided services to ordered their own prescriptions for the residents. Some homes then checked the prescriptions received themselves and resolved any discrepancies. Pharmacy team members explained that one home sent their order to the pharmacy. And, pharmacy team members then reconciled the orders against the prescriptions received and resolved any discrepancies directly with the prescriber. The pharmacy provided care homes with 28-day pack systems. And, pharmacy team members printed descriptions of the medicines in each dosage pod, so the medicines could be identified. Each pack was accompanied by a medicines administration record (MAR), which care home staff used to record each time a dose of medicines was given. The pharmacy provided the home with a set of patient information leaflets for every patients' medicines. They sent new leaflets when asked to by the care home staff. Or, when someone was prescribed a new medicine. Pharmacy team members said that the care home staff monitored renewal of leaflets. Pharmacy team members documented any changes made to people's medication on the patient's master record sheet.

But, they did not always document information about the prescriber who had initiated the changes to help deal with future queries.

Pharmacy team members checked medicine expiry dates in the ground floor dispensary every 12 weeks. And records were seen. But, some of the records seen were not up to date. They highlighted any short-dated items with a sticker on the pack up to six 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. Pharmacy team members said that medicines in the second-floor dispensary were checked every month. And, short dated items were highlighted with a sticker on the pack with the expiry date written on. These items were removed in their month of expiry. But, there were no records of expiry date checking in the second-floor dispensary. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

The pharmacy obtained medicines from five licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (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. Two were found to be correct. And, one discrepancy was identified where the register stated there were two Medikinet XL 20mg capsules in stock. But, they could not be found in the CD cabinet. The pharmacist gave an assurance that the discrepancy would be investigated and resolved or reported on as soon as possible. The pharmacy team 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.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was enrolled on a pregnancy prevention programme. The pharmacy had printed information material to give to people and to help them manage the risks. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had new scanners available. And, they had prepared SOPs to incorporate the requirements in to their practice. But, the pharmacy did not have the required software to be able to scan compliant products. The pharmacist said they were in the process of updating their software systems to be able to comply. And, they hoped this would be completed by the end of the year.

The pharmacy delivered medicines to people. It recorded the deliveries made by using an electronic system. Pharmacy team members populated the driver's schedule electronically. And the schedule was uploaded to the driver's electronic device. The system provided pharmacy team members with live information about items that were with the driver and which had already been delivered. The system also highlighted to the driver any packages that contained a controlled drug or an item that needed to be stored in the fridge. The driver asked people to sign for their medicines on the screen of an electronic hand-held device. And, the system saved the signature and the time and date of the delivery. The driver's electronic device was password protected. And, information was uploaded to the pharmacy computer system in real-time, rather than being stored on the hand-held device. 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 to arrange a re-delivery. And, the driver annotated the electronic record to record that the item had not been delivered.

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. And, pharmacy team members used a pump system to dispense methadone. Pharmacy team members calibrated the pump daily when prompted by the computer-controlled system. And, this involved them pumping a pre-defined quantity in to a conical measure, reading the quantity in the measure and recording the amount in the system. Pharmacy team members cleaned the pump every evening. The pharmacy positioned computer terminals away from public view. And these were password protected. Pharmacy team members 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.