General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M K Leeds Ltd, 58 Brudenell Road, LEEDS, West Yorkshire, LS6 1EG

Pharmacy reference: 1039692

Type of pharmacy: Community

Date of inspection: 04/02/2020

Pharmacy context

The pharmacy is in a suburb of Leeds popular with students. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service.

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 mostly identifies and manages the risks associated with its services. The pharmacy has written procedures and it keeps the records it needs to by law. The pharmacy has adequate arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The team responds appropriately when people using the pharmacy services raise concerns. The pharmacy team members respond adequately when errors happen. They discuss what happened and they act to prevent future mistakes. But they don't always record the errors. This means the team does not have information to help identify patterns and reduce mistakes. The pharmacy team has guidance to respond to safeguarding concerns to help protect the welfare of children and vulnerable adults. Not all the team members have completed training specific to their role to help the pharmacy identify and respond to safeguarding concerns.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacist owner, the qualified dispenser, the medicines counter assistant, and one of the drivers had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. The pharmacy technician who worked on a Saturday and the two recently recruited delivery drivers had not signed the SOPs signature sheet. The pharmacist owner had placed a note in the SOP folder to prompt him to ask the pharmacy technician to read the SOPs and sign the sheet. The SOPs included the roles and responsibilities of the team. The team worked within their competences. And the team regularly asked the pharmacist for advice when queries arose that they could not answer. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy had a book to record these near miss errors. But no entries had been made in 2019 and 2020. A sample of the error records that had been completed found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy had a system to electronically record dispensing incidents. But there were no records on the system. The pharmacist owner stated no dispensing incidents had happened. The pharmacist owner discussed with the team common errors. And had highlighted to the team the risks with medicines that looked alike and sounded alike (LASA). As a result, the team had separated LASA medicines such as amlodipine and amitriptyline. The pharmacist used the electronic patient medication record (PMR) to capture interventions with a person's prescriptions. Such as when one medicine had to be temporarily stopped whilst the person took a short course of another medicine.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it did not have information such as a leaflet to provide people with details on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. But it did not display the results in the pharmacy for people to see or on the NHS.uk website. Some people had asked for a better seating area for them to use when waiting for prescriptions. In response the pharmacy

installed a large couch designed to seat a few people and to support people with bad backs.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacist regularly checked stock of methadone oral solution against the balance in the register. This helped to spot errors such as missed entries. But the pharmacist did not regularly check the stock of other CDs. The pharmacy recorded CDs returned by people. And promptly destroyed them. A sample of Responsible Pharmacist (RP) records looked at found that they met legal requirements. There was no RP notice displayed at the start of the inspection. The correct notice was displayed during the inspection. A sample of records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacist had provided the team with training on the General Data Protection Regulations (GDPR). The pharmacy did not display details about the confidential data it kept and how it complied with legal requirements. The team separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures and the team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The pharmacist owner and the ACT had completed Dementia Friends training. But no other team members had completed Dementia Friends training. The delivery driver reported to the pharmacist any concerns they had about people they delivered medicines to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to provide the pharmacy's services. And they support each other in their day-to-day work. The team members discuss and share ideas. They identify and implement improvements to the delivery of pharmacy services. The pharmacy provides the team members with some level of feedback on their performance. And they have some opportunities to complete ongoing training. So, they can keep their skills and knowledge up to date. But the pharmacy doesn't always support a culture of learning to help with the continuous delivery of safe and effective services. As it doesn't encourage team members to record and learn from the mistakes that happen whilst dispensing.

Inspector's evidence

The pharmacist owner covered all the opening hours and never took a day off. The pharmacy team consisted of an accuracy checking technician (ACT) who worked on a Saturday, one part-time qualified dispenser, a full-time qualified medicines counter assistant (MCA), and three delivery drivers. A new member of the team had started a week earlier. The pharmacist owner was planning to enrol the new team member on to a dispensing course. The part-time dispenser was responsible for dispensing most of the multi-compartment compliance packs. The ACT who worked at a local hospital during the week checked most of the multi-compartment compliance packs. At the time of the inspection the pharmacist owner, the MCA and the new team member were on duty.

The pharmacy provided limited training to the team members who had completed their formal training, such as the qualified dispenser. The team were given time to go through the healthcare information leaflet produced each month for people to read and take away. The pharmacist owner kept a record when the team completed this training and any other courses they had been on. The pharmacist owner gave the team informal feedback on their performance. And asked team members to give him feedback. Team members could suggest changes to processes or new ideas of working. The team had suggested and introduced a book to record telephone conversations. This included who in the team had taken the telephone call and details of the call. So, all the team were aware of the call if queries arose. The pharmacist owner and team had recently developed a list of daily tasks that had to be completed. And displayed the list in the dispensary for all the team to refer to. The pharmacy had a whistleblowing procedure. The pharmacy did not have targets for the services offered. The pharmacist provided the services when they would benefit people.

The qualified dispenser worked part-time so the pharmacist sometimes had to dispense and check their own work. The pharmacist took a mental break between dispensing and checking their own work. This helped to spot any errors. Most of the prescriptions dispensed by the pharmacy were repeat prescriptions. The pharmacist organised the workload so most dispensing took place when the dispenser was on duty or to provide a significant amount of time between dispensing and checking their own work. The inspector discussed with the pharmacist owner the benefits of employing a locum pharmacist. So, the pharmacist owner could take a break from the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and adequate for the services provided. The team manages the limited work space well. The pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were small and located on the corner of a large building which restricted any development or refit opportunities. The pharmacy dispensary was small but the team managed the space by keeping the work benches tidy. The pharmacy was clean, it had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and gel for hand cleansing. The premises were secure and had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

The pharmacy had a sound proof consultation room located behind the pharmacy counter close to the dispensary. Due to the structure of the premises this was the only location suitable for this room. The team used this room for private conversations with people. And for people to take their methadone doses. The pharmacy did not store any confidential information in the area people used to access the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. And it mostly manages its services appropriately. The pharmacy team keeps its records about people's prescription collection requests up to date. So, this enables the team to deal with any queries effectively. But the team does not always get signatures from people for the receipt of their medicines when it delivers to people's homes. So, the team doesn't have a robust audit trail and cannot always evidence the safe delivery of people's medicines. The pharmacy obtains its medicines from reputable sources and it mostly stores and manages its medicines adequately.

Inspector's evidence

People accessed the pharmacy via a step-free entrance. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And it had a monthly healthcare leaflet providing people with information on a particular medical condition. The leaflet included a quiz to test the person's knowledge on the information provided. And it listed the pharmacy opening hours and contact details. Recent topics included the dry January campaign and raising awareness of regular eye tests and foot checks for people prescribed diabetic medication. Several team members spoke languages such as Urdu. This helped the team to ensure that people understood information such as dose instructions.

The pharmacy provided multi-compartment compliance packs to help around 70 people take their medicines. Most people received weekly supplies. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Most prescriptions were sent to the pharmacy as repeat prescription batches of seven days. A few prescriptions were sent as one month's supply which the team prepared as four weeks together. The pharmacist had assessed the needs of people with monthly prescriptions. And when necessary sent the packs weekly. The pharmacist checked received prescriptions against the list of medicines on the person's electronic medication record (PMR). And queried any changes with the GP team. The pharmacist generated the dispensing labels and backing sheet supplied with the packs before the dispenser dispensed the medicines in to the packs.

The team recorded the descriptions of the products within the packs. But the descriptions were limited to tablets and capsules rather than information such as colour and markings. The team did not always supply the manufacturer's patient information leaflets. The team stored completed packs in box files labelled with the person's name and address. The team attached notes about the person or the packs to the box files so everyone was aware. For example, if the person was in hospital. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. The pharmacist had recently used the discharge summary when querying with the GP a medicine dose on a prescription that was different to the information from the hospital. The team received forms from the GP teams about changes to people's medication. The pharmacist updated the person's PMR as soon as the form arrived at the pharmacy.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The dispensing label attached to the dose included the date of supply. The pharmacy

stored the prepared doses in alphabetical order in the controlled drugs cabinet. There was some separation between people's doses to reduce the risk of the pharmacist selecting the wrong person's dose.

The team members provided a repeat prescription ordering service. The team used the PMR to generate the prescription request and as an audit trail to track the requests. The team usually ordered the prescriptions two weeks before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The team wrote this information on to the bag label. So, the team member handing over the medication could see this information and pass it on to the person. The pharmacist had completed checks to identify people prescribed valproate who met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found one person who met the criteria. This person received 24-hour specialist care.

The pharmacy provided some separation of labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy kept a record of the delivery of medicines to people. But it only obtained signatures from the person receiving the medication for deliveries of CDs.

Several tablet bottles containing loose medicines were found in the section the team used to store medicine stock for the compliance packs. The tablet bottles were only labelled with the name of the medicine and some had the name of the person who received the pack. The batch number and expiry date of the medicines were not recorded on the label. So, the team could not check these medicines against any safety alerts that came through. And the team couldn't include these medicines in any date checks. The pharmacy team checked the expiry dates on stock. And kept a record of this. The team divided the record into different sections of the pharmacy. The record showed the last date check for some sections was on 13 December 2019. But some sections had the last date check in July 2019. The team wrote the expiry date on to the packaging to highlight medicines with a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 21 November 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had equipment and a computer upgrade to meet the requirements of the Falsified Medicines Directive (FMD). But the team were not scanning FMD compliant products. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and usually kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations 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.