General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shaan Pharmacy, 176 Harehills Lane, LEEDS, West Yorkshire, LS8 5JP

Pharmacy reference: 1088428

Type of pharmacy: Community

Date of inspection: 03/01/2024

Pharmacy context

This pharmacy is on a main road in Harehills, a large suburb of Leeds. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides multi-compartment compliance packs to many people to help them take their medication correctly. The pharmacy provides other NHS services including the hypertension case finding service. And it delivers medicines to some people's homes.

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 suitably identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows, and it mostly completes the records it needs to by law. Team members protect people's private information correctly and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond appropriately to errors by discussing what happened and taking action to prevent future mistakes.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of services. The SOPs were kept electronically and each team member had a personal log-in number to access them. Evidence the team members had read the SOPs was limited to the system showing they had read the SOP. Rather than additional information such as completing a quiz to show they had read and understood the SOPs. Some SOPs were missing such as those covering errors in the dispensing process and managing confidential information. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacist asked team members to correct mistakes found at the final check of a prescription. The pharmacy kept electronic records of these errors known as near miss errors. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error happening again. A sample showed actions such as ensuring one task was completed before starting another one. Separate records were kept for errors identified after the person received their medicine, known as dispensing incidents. All team members were informed of the dispensing incident and they discussed how to prevent such errors from happening. Team members had separated packs of aspirin enteric-coated tablets and aspirin dispersible tablets on the storage shelves to reduce the risk of dispensing the wrong preparation. The pharmacy had procedures for team members to follow when a person raised a concern about the services provided. However, information in the form of a poster or leaflet on how to give feedback was not available for people to read or take away.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The CD registers were kept electronically, and the system captured the current stock balance for each CD register which was regularly checked against the physical stock. This helped to identify issues such as missed entries. The pharmacy kept records of CDs returned by people for destruction. Records of the supply of unlicensed medicines were missing details of the person the medicine was supplied to.

Team members had received training on how to correctly manage confidential information and they separated confidential waste for shredding offsite. Information such as a privacy notice was not displayed to advise people what private information the pharmacy kept. And how it complied with legislation to keep their private information safe. Team members had received safeguarding training relevant to their role. Information on the procedures to follow when raising a safeguarding concern was clearly displayed in the dispensary for team members to refer to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely 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 receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager covered the opening hours with regular locum pharmacist support. The pharmacy team consisted of a full-time dispenser, a part-time dispenser, a full-time trainee dispenser, a full-time medicines counter assistant (MCA), two part time MCAs and a part-time delivery driver. The pharmacy was recruiting for another qualified dispenser. At the time of the inspection the pharmacist manager, one of the dispensers, the trainee dispenser and an MCA were on duty.

Team members worked well together and supported each other particularly to ensure people presenting at the pharmacy counter were not kept waiting. They were trained on key tasks to ensure they knew how to complete these tasks especially at times of unplanned absence which may impact on the team's workload.

The pharmacy provided team members with additional training to keep their knowledge up to date. This included mandatory training covering legal requirements, and when new services were introduced. The team held regular meetings and all team members were encouraged to contribute.

The pharmacist owner regularly attended the pharmacy and spoke individually to each team member to give them feedback and discuss their training and development. One of the dispensers had taken the opportunity to ask about training to be a supervisor which had been agreed. And they'd also been asked to consider doing the accuracy checking course to support the pharmacist when new NHS services were introduced.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises had undergone a refit since the last inspection which had created plenty of space for team members to work and was professional in appearance. The team kept the premises tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, and alcohol gel was also available for hand cleansing. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. 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 large, soundproof consultation room that was used for private conversations with people and when providing services. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. It obtains its medicines from reputable sources and it stores them properly. Team members carry out checks to make sure medicines are in good condition and appropriate to supply. However, they do not always provide people with information about their medicines to help them take their medication correctly.

Inspector's evidence

People accessed the pharmacy via a step-free access. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And team members provided people with information on how to access other healthcare services. Team members asked appropriate questions when selling over-the-counter products and knew when to refer to the pharmacist. Some team members spoke Urdu and the team accessed an online platform to translate other languages. This helped to ensure people received the correct information about their medication. The computer on the pharmacy counter had access to the electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at. The NHS hypertension case finding service was popular and several people had been referred to their GP for further tests. All team members had been trained on the specifications of the service and were observed actively promoting the service and explaining how it worked. This resulted in people agreeing to have their BP checked whilst they were in the pharmacy.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. To manage the workload the team divided the preparation of the packs across the month. Most prescriptions were ordered several days before supply to allow time to deal with issues such as missing items. However, CD prescriptions were often sent to the pharmacy either the day before supply or on the day of supply. This meant there was less time to check the prescription, order the medication and dispense the prescription. The pharmacist identified the risks with dispensing within this tight timeframe and planned to contact the GP teams to arrange for prescriptions to be sent a few days before supply. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of the packs. The team did not record the descriptions of the medicines within the packs and did not always supply the manufacturer's packaging leaflets. This meant people did not have information to help them identify the medicines in the packs and details about their medication. The pharmacy received copies of hospital discharge summaries via the NHS communication system. The team checked the discharge summary for changes or new items.

Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the recent changes requiring valproate to be dispensed in the manufacturer's original pack. But the pharmacy didn't review people prescribed valproate to identify anyone who may meet the PPP criteria and team members were unsure if anyone prescribed valproate met the criteria.

The pharmacy provided plenty of space for the team to work and it had separate areas for labelling, dispensing and checking of prescriptions. Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The 'checked by' and 'dispensed by' boxes on dispensing labels were not always initialled to show which team members

had completed these tasks. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the medicines it had delivered to people. If the person was not at home the delivery driver left a note informing the person of the attempted delivery.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock and kept a record of this. They generally marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found but two boxes of medicines with expiry dates in February 2024 were found without any markings. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and sample of these records 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 CDs separate from in-date CD stock in a secure cabinet. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and a phone call. The team took appropriate action in response to the alert to ensure the affected medicine stock was removed from use.

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 references 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 to hold medicines requiring storage at these temperatures. One of the fridges had a glass door to enable stock to be viewed without prolonged opening of the door.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. They were positioned in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and other private information was stored in the dispensary and rear areas, which 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.