

Registered pharmacy inspection report

Pharmacy Name: K L Pharmacy, 1 - 2 Tyler Road, SOUTHALL,
Middlesex, UB2 4XQ

Pharmacy reference: 1092896

Type of pharmacy: Community

Date of inspection: 07/02/2024

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is in a small local shopping centre alongside other local shops and services. And it is in a residential area of Southall. It provides a range of services including dispensing prescriptions. And it has a small selection of over-the-counter medicines and other pharmacy related products for sale. It provides a selection of other services, including a winter flu vaccination 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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

The pharmacy risk assessed its services. And it provided non-essential services when the workload allowed. The responsible pharmacist (RP) was the regular RP. She was also the superintendent. The pharmacy had a small team. And the RP described how she would only introduce new services when she felt that the team was fully equipped to deliver them safely and effectively. And so, she had not yet registered for the new NHS England Pharmacy First service. But she hoped to do so soon. The pharmacy had systems in place for recording its mistakes. The RP described how she generally highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team did not appear to make many mistakes. But when it did, it discussed them. And it usually recorded them. The RP then reviewed them monthly. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs, it had separated several of these products to different areas of the dispensary. And it had placed warning stickers on the shelf edges in front of them. This included Tramadol and Trazadone. It had done this to reduce the risk of selecting the wrong medicine. But the team recognised that preventing such mistakes required ongoing monitoring and intervention. And while it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record the detail of what its team members had learned or how they would improve. And they did not always identify the steps they could introduce to their own procedures to help further prevent future mistakes. The RP, and inspector discussed this and agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. And by team members recording what their follow up actions would be, it would also help the RP to monitor learning and improvement more effectively.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. Team members understood their roles and responsibilities. And they had all read and signed the SOPs. Including SOPs for selling pharmacy medicines and general items. And when handing out people's prescriptions. The dispensing assistant (DA) worked with the RP to get prescriptions ready for people. And she consulted the pharmacist when she needed her advice and expertise. She asked people appropriate questions about their prescriptions, to ensure they got what they needed. And she accessed, used and updated the pharmacy's electronic records competently. The RP had placed her RP notice on display showing her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any

concerns at the time. The RP commented that, at times, people were concerned when their prescription had not arrived or that their medicines were not ready or available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But, to help the situation, the team chased prescriptions up when they could. And they also worked closely with the surgery to arrange for alternatives when they received a prescription for an item that they could not get. The pharmacy also tried to keep people's preferred brands of medicines in stock so that their medicines were available for them when they needed them. The small team was observed handling people's queries well. And the RP and DA stepped in, unprompted, to support each other when needed. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy kept its records in the way it was meant to, including its RP records, private prescription records, records for emergency supplies. And its CD register. The pharmacy kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. It was clear that the RP understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy had a policy on confidentiality. Its team members understood the need to protect people's confidentiality. And they completed regular training to keep their knowledge up to date. They shredded confidential paper waste throughout the day, as they worked. And they kept people's personal information, including their prescription details, out of public view. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. And it had made appropriate safeguarding referrals in the past.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality and effectiveness of the pharmacy's services.

Inspector's evidence

The pharmacy had a small, established close-knit team. And on the day of the inspection the team consisted of the RP and the DA. The RP worked part-time at the pharmacy and part-time in the local GP practice. And so, the pharmacy had two-part time locums to cover remaining shifts. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. It kept on top of its other tasks. And it dealt with queries promptly.

Team members had annual one-to-one meetings to discuss their work performance. The RP and DA also discussed issues as they worked. And they described being able to give feedback to one another. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. The DA supported locum pharmacists to make dispensing decisions based on the most up-to-date drug tariff changes. And helped them to follow the pharmacy's procedures for dispensing 'paid for' items. She did this to reduce waste, improve availability and to reduce time spent dispensing items which people did not then collect. This was a family run independent pharmacy. And the RP felt she could make day-to-day professional decisions in the interest of patients. She also supported locums to provide additional services when circumstances allowed. And when they had the appropriate skills to do so.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide an environment which is appropriate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was in a small shopping centre, alongside other local shops and services. It shared its ownership with the convenience store next door to which it was attached. It had a small retail area with a seat for waiting customers. It also had a consultation room which was close to the counter and dispensary. The consultation room provided a place for people to receive pharmacy services or have a private conversation with the pharmacist. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. Team members shared staff facilities with the convenience store. And they accessed the facilities using the front entrances for each premises. The pharmacy stored its dispensed medicines in the dispensary where staff could locate them easily while keeping people's private information safe. It kept its pharmacy medicines behind the counter.

The pharmacy had a compact dispensary. But it had enough space for team members to dispense the pharmacy's multi-compartment compliance packs. The dispensary had dispensing benches on two sides which were used for the pharmacy's dispensing activities. And it had storage facilities above and below the benches. One of the dispensary's workstations faced the retail space and the back of the medicines counter, so that team members could see people waiting. The pharmacy had a cleaning routine. And it kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members cleaned floors periodically and they tried to keep them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had information on its windows promoting its services. And it had a doorway which provided step-free entry. Its customer area was small but free of unnecessary obstacles. And so, it was suitable for people with mobility issues. The pharmacy could order people's repeat prescriptions if required. And it had a delivery service. But the pharmacy tried to prioritise the service for people who had no other way of getting their medicines. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The DA processed the prescriptions for the compliance packs. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. The inspector discussed the clarity of the descriptions with the team. And it was agreed that the descriptions should be clear. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so, people may not have all the necessary information about their medicines to help them to take their medicines properly. The inspector and the team agreed that it was important to ensure that people had all the information they needed about their medicines. Pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, some of whom were in the at-risk group. The RP counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also knew to provide warning cards and information leaflets with each supply. And she was aware of recent changes in the law about supplying valproate medicines in their original packs.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines appropriately. And stock on the shelves was tidy and organised. But the inspector found an amber dispensing bottle containing loose tablets in amongst stock. The bottle had a label identifying the name and strength of contents. But it did not contain all the required manufacturer's information about the tablets inside. And while this did not present a high risk of error, it may mean that the contents could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing.

The pharmacy checked the expiry dates of its stock, regularly. And it kept records. When the team identified any short-dated items it highlighted them. And it removed them from stock. It only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. But the RP agreed that team members should review their understanding of how to take accurate fridge temperature readings. And how to reset the thermometer. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had two computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view. The pharmacy had a shredder which it used regularly to dispose of confidential paper waste appropriately.

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. |