General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Al-Shafa Pharmacy, 267 Dewsbury Road, Beeston, LEEDS, West Yorkshire, LS11 5HZ

Pharmacy reference: 1104967

Type of pharmacy: Community

Date of inspection: 16/11/2021

Pharmacy context

This community pharmacy is in a large suburb close to Leeds City Centre. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides several people with multi-compartment compliance packs to help them take their medicines. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy has written procedures for managing errors in the dispensing process, but the team members do not fully follow them. They don't regularly keep records of near miss errors and dispensing incidents. This is a repeated finding from the last inspection. So, the improvements the pharmacy showed after the last inspection are not being maintained. The pharmacy continues to miss opportunities for learning.
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 not all met	4.2	Standard not met	The pharmacy doesn't have effective procedures to ensure medicines dispensed into multi-compartment compliance packs remain stable and suitable for people to take. The pharmacy leaves some dispensed medicines in unsealed packs and on top of each other for prolong periods of time. This means the medicines are at risk of moving between the packs. And contaminants may enter the packs resulting in the medication becoming unstable. This is a repeated finding from the last inspection.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy adequately identifies and manages some of the risks associated with its services. But team members do not fully follow all of the pharmacy's written procedures. This includes managing errors in the dispensing process. They don’t keep records when things go wrong. So, they don’t have all the information to learn from their mistakes, and prevent similar errors from happening again. The pharmacy keeps the records it needs to by law and it protects people’s confidential information. The team members have a clear understanding of their role in safeguarding the safety and wellbeing of children and vulnerable adults.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The team members wore Personal Protective Equipment (PPE) face masks during the inspection. And they regularly used hand sanitising gel. The pharmacy had two chairs in the small waiting area. These were sufficiently spaced apart to support social distancing requirements. The pharmacy displayed a range of posters in the retail area providing people with information about the COVID-19 pandemic and how to prevent the virus from spreading.

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 team had read the SOPs but not all the team members had signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

On most occasions the pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy had systems in place to enable the team to keep records of these errors known as near miss errors. These records had changed from a paper version to an electronic version in August 2021. However, no entries had been made since August 2021. The Superintendent Pharmacist (SI) commented that near miss errors had occurred since August 2021 but had not been recorded. The paper version of the near miss record showed the last entry was made in May 2021. This meant the team didn’t have information to spot patterns and make changes to prevent similar errors from happening again. Most of the team members were trainee dispensers and the recording of their errors was an important element of their training and development. The records made in August 2021 showed some learning and captured the actions taken by the team to prevent similar errors. The pharmacy had a procedure for handling errors that reached the person known as dispensing incidents. This included a template for the team to record dispensing incidents but the pharmacy didn’t have any records to demonstrate this had happened. The SI explained a recent dispensing incident had been reported on to the national database but not on to the pharmacy records. This dispensing incident had involved the incorrect supply of a medicine that looked and sounded like the medicine that had been prescribed. The SI had shared the error with all the team to learn from and had separated the two products. The previous inspection in 2019 found that the pharmacy was not regularly keeping near miss records and records of dispensing incidents. Following the inspection in 2019 the SI implemented a process requiring the pharmacist to complete the records. The inspector discussed with the SI at this inspection the option of asking the team members to complete the near

miss record to ensure the record was made. And to provide them with an opportunity to reflect and learn from their error. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the pharmacy website provided people with information on how to raise a concern. The team had received positive feedback from several people about the services it provided to the local community during the pandemic.

The pharmacy had up-to-date 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 CD registers were kept electronically. The system captured the current stock balance for each CD register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. However, a sample of entries showed no balance checks had been completed in recent months. A sample of records of supplies from private prescriptions met legal requirements. The SI, as part of the legal and clinical check, verified the registration status of the prescriber when receiving a prescription for the first time from the prescriber.

The team had received training on how to manage confidential information and the requirements of the General Data Protection Regulations (GDPR). The pharmacy did not display details on the confidential data it kept and how it complied with legal requirements. It also didn't display a separate privacy notice. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And the team had received safeguarding training along with suicide awareness training. The team responded well when safeguarding concerns arose. The delivery drivers reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of skills and experience to support its services. Team members work well together and support each other in their day-to-day work. They frequently discuss ideas to enhance the delivery of the pharmacy's services. Pharmacy team members receive feedback on their performance and they are supported to complete ongoing training. This helps them to keep their knowledge and skills up to date.

Inspector's evidence

The Superintendent Pharmacist (SI) worked full-time at the pharmacy. After the regular locum pharmacist left a few months earlier the SI struggled to get locum pharmacist cover. The SI reported this had recently improved slightly as a regular locum pharmacist had started to support the pharmacy. The pharmacy team consisted of a full-time trainee pharmacist, two full-time trainee dispensers, two part-time trainee dispensers, a new part-time team member in post for two months and two part-time delivery drivers who had been in post a few years. At the time of the inspection the SI, the trainee pharmacist, a trainee dispenser, and the new team member were on duty. The SI was the supervisor for the trainee pharmacist and the two had discussed the plans for the training year. The pharmacy team had recently returned to a full complement of staff after several months of disruption as team members had been off work with issues related to the pandemic. The team had worked well together during this time to ensure the pharmacy services were not affected.

The pharmacy provided team members with protected time for training. And the SI supported the trainees by offering to spend time with them particularly on aspects of the course they found difficult. The pharmacy provided all team members with a range of training modules to keep their knowledge up to date. The pharmacy provided formal performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs. The person from the company responsible for the performance reviews was new to this role and had recently visited the pharmacy to meet each team member and discuss their roles. The SI was invited to provide feedback about each team member to the person conducting the review.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the team members had recently shared concerns about the number of requests for codeine linctus. And they discussed why this was happening. The pharmacy didn't stock the product and discussed how to manage such requests and where to refer people when required. This had led the team to discuss other medicines of concern and how to manage requests to purchase them. The SI had taken the opportunity of having new team members to remind everyone in the team to always raise any concerns with him. And encouraged them to do so no matter how trivial the team member felt the concern was. The SI advised the team it was his responsibility to respond to the concern and to take any appropriate action.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. The pharmacy had separate sinks for the preparation of medicines and hand washing. The dispensary was small with limited space to work. The team managed this by working in an organised manner and mostly keeping floor spaces clear to reduce the risk of trip hazards. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a small, soundproof consultation room which the team used when providing services such as the flu vaccination.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always manage its services with sufficient care. Some processes the team members follow to dispense medicines in multi-compartment compliance packs increase the risk of error. And the method they use to store some of the medicines in these packs runs the risk that they may not be suitable for people to take. The pharmacy provides services which are easily accessible for people. It gets its medicines from reputable sources. And the pharmacy team carries out checks to make sure most medicines are in good condition and suitable to supply.

Inspector's evidence

People using the pharmacy were able to easily access the premises and were mostly from the local area. Team members spoke various South Asian languages which helped to ensure people received the correct information, advice and medical treatments when requesting an over-the-counter (OTC) medicine. The pharmacy provided a minor ailments scheme which was popular. And it provided the seasonal flu vaccination service. The SI was the only trained vaccinator so people were mostly offered an appointment rather than a walk-in service. The pharmacy supplied private COVID-19 testing kits that were provided by companies listed on the HM Government website which had declared they met the minimum standards for these tests.

The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had PPP information to provide to people when required. The pharmacy had completed a check of people who were prescribed valproate and found there was no-one who met the PPP criteria. The pharmacy supplied some medicines to people as daily supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses securely as required but didn't separate individual people's doses. So, there was a risk that people may receive the wrong dose.

The pharmacy received copies of hospital discharge summaries via the NHS discharge medicines service (DMS). The pharmacists checked prescriptions sent from the GP team against the discharge summary to identify any discrepancies. The SI reported this was a very useful service. And demonstrated two occasions when the prescriptions received didn't have updated details when checked against the discharge summary. The SI had contacted the GP team to advise of this and arranged for the correct prescriptions to be sent.

The pharmacy provided multi-compartment compliance packs to help around 120 people take their medicines. It also provided packs to people living in two small care homes. To manage the workload the team divided the preparation of the packs across the month. The team ordered prescriptions several days in advance of supply. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. The care home teams used the prescription repeat slips to indicate the medications needed and sent them to the pharmacy to order the prescriptions. The dispensary had limited workspace available so the team used a small area to the rear of the dispensary to prepare the packs. This provided some protection from the distraction of the retail area. The team members wore disposable gloves when dispensing the medicines into the packs. And they kept the empty medicine packets in baskets with the packs for the pharmacist to refer to when performing the

final check. The team often prepared the packs before all the medication was available. The incomplete packs were left unsealed and on top of each other whilst waiting for the remaining items to arrive. This ran the risk of medication moving between the packs or the packs being knocked over. It also ran the risk of dust or other contaminants entering the packs and the medication becoming unstable. The SI explained the packs were sometimes left unsealed overnight. This was an issue highlighted to the SI at the last inspection in 2019. The team recorded the descriptions of the products within the packs. But they didn't always supply the manufacturer's packaging leaflets. This meant people may not have all the information about their medicines.

The pharmacy team used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. 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 of dispensed medicines found the team completed the boxes. The pharmacy kept a record of the delivery of medicines to people. Due to the pandemic the pharmacy didn't ask for a signature from the person receiving the medication. The delivery driver marked the delivery sheet to indicate the medication had been handed over. The pharmacy asked people who tested positive for COVID-19 to inform the team so this could be passed on to the drivers to ensure they took appropriate steps to protect themselves. If the person was not at home the delivery driver usually tried a second time before leaving a note informing the person of the failed delivery. Due to the increased number of people asking for the service the SI decided to only attempt a re-delivery once. After that the team would ask the person to arrange for the medication to be collected from the pharmacy.

The pharmacy obtained medication from several reputable sources. The team managed the limited shelf space in the dispensary by storing most medicines in large clear plastic tubs labelled alphabetically. This helped the team to easily locate stock and to reduce picking errors. The pharmacy team checked the expiry dates on stock and kept a record of this. The team members 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. The team members recorded the dates of opening on to medicines with altered shelf-lives after opening. This meant they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A 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 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 received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) electronically which the team read and took appropriate action.

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 resources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door that enabled the team to see the stock inside without prolong opening of the door.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy stored completed prescriptions away from public view. The pharmacy held private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.