General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Shifa Pharmacy, 225 Chapeltown Road, LEEDS, West Yorkshire, LS7 3DX

Pharmacy reference: 1108668

Type of pharmacy: Community

Date of inspection: 10/07/2019

Pharmacy context

The pharmacy is amongst a parade of shops in Chapeltown, a large suburb north of Leeds City Centre. The pharmacy dispenses NHS and private prescriptions. And it provides a travel vaccination service. The pharmacy orders repeat prescriptions for people and delivers medicines to people.

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	4.1	Good practice	The pharmacy team members identify the problems some people have when accessing pharmacy services. Or receiving information to help them manage their medical conditions. And they take steps to overcome these problems. The pharmacist providing the travel vaccination service has completed an extensive range of training courses. So, people using this service receive the correct treatment and up-to-date information.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy generally identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures for the team to follow. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they act to prevent future mistakes. People using the pharmacy can provide feedback on its services. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. But not all pharmacy procedures have been recently reviewed or signed by all the team. This means there is a risk that team members may not be following up-to-date procedures. And they don't record all errors or the outcome from reviewing the errors. This means that the team does not have information to identify patterns and reduce mistakes.

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. Some of the SOPs had review dates of 2013 and others had reviews dates of 2015. But the pharmacy hadn't completed any reviews of the SOPs. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Some of the team had read and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy had up to date Indemnity insurance.

The pharmacy had a template for the team to record errors picked up when the pharmacist checked prescriptions. But the templates only showed a small number of records. The pharmacy team had not captured any errors since March 2019. The pharmacy recorded dispensing incidents electronically. But only one of the regular pharmacists could use the reporting system. This meant there could be a delay in reporting the error. And a risk that the dispensing incident may not be recorded. One of the pharmacists reviewed the dispensing errors and any other patient safety incidents. And shared the outcome of the review with the team. The pharmacist didn't keep a record the review or the actions taken as a result.

The pharmacy completed an annual patient safety report. The report covering the period from February 2018 to January 2019 stated that the team members were to improve their understanding of the risks associated with dispensing incidents. And they were to separate medicines that looked and sounded alike (LASA). The report stated that the pharmacists were ensuring they included a check of expiry dates on medicines as part of the accuracy check of prescriptions. The report stated this was because the team had missed some out of date products when checking the stock on shelves. The report stated that the team was aware that errors were more common with one-off prescriptions, rather than repeat prescriptions. The report also stated that the team were to improve the communications with GP teams and local pharmacies to learn from mistakes. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a poster providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. And it published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found several did not have the header completed. Some registers were not attached to the folder holding them which ran the risk of losing them. The

pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found they met legal requirements. The Responsible Pharmacist notice on display was incorrect but corrected during the inspection. 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 did not meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy had a folder containing documents related to information governance (IG). There was no evidence that the team had read this information. The team had received training on the General Data Protection Regulations (GDPR). The pharmacy did not display a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacy had a safeguarding procedure, but this had not been reviewed since April 2012. The pharmacists had completed level 2 training in 2018 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And as part of the training for providing the travel vaccine service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the qualifications and skills to support the pharmacy's services. But new members of the team occasionally undertake tasks they are not receiving training for. The team sometimes share information and learning particularly from errors when dispensing. The team members discuss how they can make improvements. And they act to support the safe and efficient delivery of these services.

Inspector's evidence

Three regular pharmacists including the Superintendent Pharmacist covered the opening hours. The pharmacists overlapped most days particularly in the afternoon when the pharmacy was busy. The pharmacy team included members of the team who started around two months ago. These team members were to be enrolled on to a medicines counter assistant course once they reached their three months' probation. The pharmacy did not have any dispensers. The pharmacists did the dispensing and checked each other's work. During the inspection one of the new team members did some labelling and picking stock. But was not enrolled on a course to support this activity. The team members worked similar hours. Rather than starting at different times to enable the pharmacists to have team support across the opening hours. The pharmacy had a delivery driver who usually worked of an evening.

The pharmacists used a communication tool on the computer to record information for each other and the team. The regular pharmacists discussed opportunities to improve the delivery of the pharmacy services and make changes. One of the regular pharmacists had introduced the email system for ordering repeat prescriptions. And trained the other pharmacists on how to do this. This change provided the team with clearer information for tracking prescription requests. The pharmacy did not have targets for services such as Medicine Use Reviews (MURs). The pharmacists offered these services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room did not contain a sink. But alcohol gel was available for hand cleansing. The pharmacy had enough storage space for stock, assembled medicines and medical devices. But the team kept a few baskets holding prescriptions and dispensed items on the floor.

The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The pharmacist had risk assessed the room to ensure it was suitable for the travel vaccine service. The premises were secure. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy team members identify the problems some people have when accessing pharmacy services. Or receiving information to help them manage their medical conditions. And they take steps to overcome these problems. The pharmacist providing the travel vaccination service has completed an extensive range of training courses. So, people using this service receive the correct treatment and up-to-date information. The pharmacy manages its services adequately. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines appropriately. But the team does not describe the medication put in to multi-compartmental compliance packs to help people take their medicines safely. And it does not always record who had dispensed and checked the prescription. So, the team doesn't have details of who was involved when dealing with any queries.

Inspector's evidence

People accessed the pharmacy via a small step. The window displays detailed the opening times and the services offered. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy team members spoke several different languages including Urdu and Punjabi. So, they could help people understand about their medical conditions and how to take their medicines. The pharmacy provided over-the-counter products such as paracetamol liquid via a minor ailments scheme known as Pharmacy First. This was instead of a visit to the GP and getting a prescription.

The pharmacy team supported people diagnosed with chronic medical conditions. These included diabetes and high blood pressure. The pharmacy offered free diabetes and blood pressure checks. The blood pressure checks were usually done over a seven-day period. So, the pharmacists could see any variations. The pharmacists passed on the results from the checks to the person's GP for appropriate medicines to be prescribed. The pharmacist spent time with people explaining the causes of these medical conditions. And the steps the person could take to manage their medical condition.

The pharmacy provided the travel vaccines against up to date patient group directions (PGDs). The PGDs gave the pharmacist the legal authority to administer the vaccine. The pharmacist had completed training courses on travel vaccines and travel health to support this service. And was completing another course through the Liverpool School of Tropical Medicine. The pharmacist had also received training from a specialist nurse. This training included the technique to administer vaccines and how to deal with an anaphylactic reaction. The meningococcal vaccine (ACWY) for people traveling to Hajj was popular. People rang the pharmacy and were offered an appointment. The pharmacist explained to people how long the appointment would be. And that the person needed to stay in the pharmacy after the pharmacist administered the vaccine to ensure they didn't have a reaction. The pharmacist ensured people receiving the vaccine were also provided with information on how to stay healthy when travelling.

The pharmacy provided multi-compartmental compliance packs to help around 90 people take their medicines. One of the regular pharmacists managed this service with support from the other pharmacists. People received weekly supplies, so the team could manage medicine changes. And

identify any concerns with the person taking their medicines. To manage the workload the team divided the preparation of the packs across the month. The pharmacy had a list of people who received the packs and when they were due. The pharmacists used the list to mark off when they had completed the processing of the packs. The team usually prepared the packs a week before supply. This allowed time to order the prescriptions and deal with issues such as missing items. Before dispensing the medication in to the packs. The team checked received prescriptions against the list of medicines on the electronic patient medication record (PMR). The pharmacists used a small room off the main dispensary to dispense the packs. So, they were away from any distractions when dispensing and checking the packs. The team supplied the manufacturer's patient information leaflets. But it did not record the descriptions of the products within the packs to help people identify their medicines. The team separately bagged and labelled completed packs. And stored them ready for supply on the day they were due. 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 team updated the PMR with details of medication changes. And it updated the backing sheet that went with the packs.

The team members provided a repeat prescription ordering service. They used an electronic system to remind them when they had to request the prescription. The team emailed the prescriptions requests. And used this as an audit trail to track the requests. The team sent some prescription requests by fax and kept a paper record of this. The team regularly checked the email list and the paper record to identify missing prescriptions to chase up with the GP team. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy monitored people on high risk medicines and recorded any information provided on the person's PMR. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the PPP criteria. The pharmacy did not have the PPP pack available to provide information to people when required. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored dispensed doses due that day in the same basket. But didn't separate people's doses to help prevent the team selecting the wrong person's dose. The pharmacy put the bottles containing doses taken away by people in bags.

The pharmacy provided separate areas for 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 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 rarely completed the boxes. On occasion the pharmacist had to dispense and check their own work. When this happened, the pharmacist took a mental break between dispensing and checking. This helped to spot errors. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. 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 kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. The team marked the medicine packs 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 levothyroxine with eight weeks use once opened had a date of opening of 11 June 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 pharmacy stored the CDs in drawers within the cabinet labelled with the stock held. So, the team could easily locate the item. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had the equipment and computer upgrade to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacy was updating the written procedures to cover FMD. But the pharmacy team was not using the scanners for FMD. 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 and actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. But the team doesn't always take the necessary steps 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 an Omron machine for checking people's blood pressure. And it had two fridges to store medicines kept at these temperatures. One fridge was for general stock, the other was for the travel vaccines.

The computers were password protected and access to peoples' 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 most private information in the dispensary and rear areas, which had restricted access. But some completed consent forms from the travel vaccine service that contained people's confidential information were in the consultation room. The pharmacy 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.