General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Khan Pharmacy, 168 Roundhay Road, LEEDS, LS8 5PL

Pharmacy reference: 1112225

Type of pharmacy: Community

Date of inspection: 10/02/2022

Pharmacy context

This community pharmacy is in a large suburb of Leeds. The pharmacy's main activities are dispensing NHS and private prescriptions. The pharmacy provides some medicines in multi-compartment compliance packs to help people take their medication. The pharmacy offers an online private GP video-link consultation service. 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	Pharmacy team members do not record any near miss errors and dispensing incidents. And they cannot evidence any changes they make to reduce the risk of similar errors happening. The pharmacy has a written procedure, but the team members do not follow it to reduce the risk of errors and learn from them.
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 not all met**

Summary findings

The pharmacy identifies and manages some of the risks associated with its services. But team members do not keep any records when things go wrong. And they cannot evidence any learning to reduce errors. The team generally has suitable arrangements to protect people's private information. And it keeps the records it needs to by law. The team has some knowledge of how to identify and raise a safeguarding concern. But one of the regular pharmacists is not up-to-date with their training.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had installed a plastic screen on the pharmacy counter to provide the team with protection. The retail area was large enough to allow people to be socially distanced from each other. The dispensary was small but team members mostly kept some distance from each other. The team didn't wear Personal Protective Equipment (PPE) and the pharmacy didn't ask people to wear face coverings when presenting at the pharmacy.

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. Most team members had had read and signed the SOPs signature sheets to show they understood and would follow the SOPs. The team referred queries from people to the pharmacist when necessary. The pharmacy offered a UK based online GP consultation and prescription service that people used in the pharmacy. People made an appointment to use the service through the pharmacy. And attended the pharmacy in person to undertake a remote consultation with a GP via a video link. The service was well managed but the pharmacy didn't have a SOP for this service. And it hadn't risk assessed the service to ensure it was managing the service appropriately.

The pharmacy had a written procedure for handling errors in the dispensing process known as near miss errors. The procedure included the recording of the near miss errors and the pharmacy had a book to record these errors. But the team had not recorded any errors since 2019. The pharmacy had a procedure to record errors that reached the person, known as dispensing incidents. The procedure included the requirement to record these errors. But the pharmacy didn't keep such records. The team members knew there had been near miss errors and dispensing incidents but these were not recorded. And the team members were not able to describe the errors and the actions taken to prevent the errors from happening again. This meant the team members who included trainee dispensers were missing opportunities to learn from their own errors. And for all team members to identify patterns with similar errors and prevent them from happening again. The lack of a record of near miss errors and dispensing incidents was highlighted at an inspection in 2018. The pharmacy addressed this at the time by introducing a book to record these errors. The pharmacy had a procedure for the team to follow when a person raised a complaint. And a poster displayed in the retail area provided information to people on how to give feedback about the pharmacy services or raise a concern.

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 pharmacy's SOPs required a weekly check of the CD to help spot errors such as missed entries. But a sample of CD registers showed this didn't happen. Some of the CD registers were coming loose from the folder, which ran the risk of losing them. The pharmacy didn't display details on the confidential

data kept and how it complied with legal requirements. The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures for the team to follow and team members had access to contact numbers for local safeguarding teams. The pharmacist had not completed any training such as the level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members who delivered medication to people at home reported any concerns about a person to the person's GP. The team members were aware of the Ask for ANI (action needed immediately) initiative but had not had an occasion when a person presented at the pharmacy asking about it.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a range of skills and experience to support its services. The team members support each other in their day-to-day work. And they make suggestions and implement changes to improve their efficiency and safety in the way they work. But the team members don’t take opportunities to reflect and learn from any mistakes they make. So, they may miss the chance to further develop their knowledge and skills.

Inspector's evidence

The previous pharmacy owner worked as the regular pharmacist and covered most of the opening hours. The current pharmacist owner and a regular locum pharmacist mostly covered the evenings and weekend hours. The pharmacy team consisted of two part-time trainee pharmacy technicians, two part-time qualified dispensers, one full-time trainee dispenser and one part-time medicines counter assistant. One of the trainee pharmacy technicians was also the pharmacy supervisor.

The trainees had protected time to complete training but they were not regularly provided with opportunities to identify, record and learn from their mistakes. This meant they missed the chance to reflect on their knowledge and skills and to take action to prevent similar mistakes.

The pharmacy held regular meetings. And the supervisor held monthly one-to-one meetings with team members to discuss aspect such as the progress of their training or any concerns they had. The team members could suggest changes to processes or new ideas of working. For example, one team member had suggested and implemented a tool for team members to capture when they had completed one of the daily tasks assigned to them. The team used these sheets to ensure the tasks, such as date checking, were completed and who had completed them.

Principle 3 - Premises ✔ Standards met

Summary findings

The environment of the premises generally supports the safe delivery of its services. And it has suitable arrangements for people to have private conversations with the team.

Inspector's evidence

The dispensary was small but the team managed this to ensure there was sufficient space to work. The team kept the floor spaces in the dispensary clear to reduce the risk of trip hazards. The pharmacy premises were secure and the team restricted access to the dispensary during the opening hours. The team members kept the pharmacy clean and they used separate sinks for the preparation of medicines and hand washing. Team members had access to and used hand sanitisers. The pharmacy had an appropriately sized, soundproof consultation room. The team used this for private conversations with people.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible to people. And it adequately manages most of its services to help people receive appropriate care. The pharmacy keeps records of the deliveries it makes to people. So, the team can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it generally manages its medicines sufficiently well. But the pharmacy doesn't always appropriately label and store some medicines as it should.

Inspector's evidence

The pharmacy team accessed the internet to signpost people requiring other healthcare services. And the pharmacy had a small range of healthcare information leaflets for people to read and take away. The pharmacy supported people to access a private UK based online GP consultation and prescribing service from the pharmacy's consultation room. People booked an appointment through the pharmacy to access the service. When the person presented at the pharmacy, they were invited into the consultation room where a video link connected them to the GP. If a prescription was issued the person had a choice to have the prescription dispensed at the pharmacy or at another pharmacy. The pharmacy hadn't audited the service to ensure it was provided safely. And the pharmacy didn't ask people who used the service for feedback to identify any areas of concern. The team members provided people with clear advice on how to use their medicines and were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP).

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions in advance before supply to allow time to deal with issues such as missing items and the dispensing of the medication into the packs. Each person had a record listing their current medication and dose times. The team recorded the descriptions of the products within the packs and mostly supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy provided some space to enable the team to have separate areas for labelling, dispensing and checking of prescriptions. Baskets were used 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 found the team completed both boxes. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record. 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 dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team 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 team kept medication removed from the original packs in bottles. Several of these bottles weren't labelled with details of the medication inside or the batch number and expiry date of the medicine. This practice meant the team members would not know if the medication was in date and they couldn't identify if the bottle contained affected stock if a safety alert came through. The last inspection highlighted similar issues with the safe storage and management of stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide safe services. And it mostly uses the equipment to suitably protect people’s private information. But the team members don’t always keep areas of the pharmacy where they store people’s private information secure.

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 had appropriate equipment available for the services provided. The fridge used to store medicines was from a recognised supplier and a suitable size for the volume of medicines requiring storage at such temperatures. The fridge had a glass door to enable stock to be viewed without prolong opening of the door. The fridge was at the correct temperature. But the digital display didn't always show the current temperature. This meant the team members couldn't easily read and monitor the temperature throughout the day. If a team member wanted to check the temperature throughout the day, they had to reset the display. The pharmacy had another thermometer inside the fridge that provided detailed data on the fridge temperature readings throughout the day. The pharmacy had recently purchased the fridge but the team hadn’t reported this issue to the manufacturer. The pharmacy completed safety checks on its electrical equipment.

The pharmacy 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 team members kept some people's sensitive information in the dispensary which had restricted access. But they didn't securely store all completed prescriptions as they should to reduce the risk of unauthorised access to people's private information.

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.