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: 11/01/2023

Pharmacy context

This community pharmacy is in a large suburb of Leeds. The pharmacy's main activity is dispensing NHS prescriptions. It provides some medicines in multi-compartment compliance packs to help people take their medication. And it offers the NHS hypertension case finding 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 generally identifies and manages the risks associated with its services. It has written procedures that the pharmacy team follows, and it completes the records it needs to by law. The pharmacy protects people's private information correctly and the team has training and guidance to respond to safeguarding concerns. Team members respond appropriately when errors occur, they record what happened and they act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. All the team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. They understood their roles and referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure to manage errors spotted during the dispensing process known as near miss errors. And it had a separate procedure for errors that were identified after the person received their medicines, known as dispensing incidents. The procedures included keeping a record of the near miss errors and dispensing incidents. A sample of records showed the detail captured included the reason for the error and the actions the team took to prevent the error from happening again. However, the records were completed by the pharmacist rather than the team member involved. This meant the team members missed out on an opportunity to reflect on their own errors and learn from them. The Superintendent Pharmacist reviewed the records and discussed key themes with the team. And discussed the actions to take to help prevent errors such as separating stock and keeping the dispensary shelves tidy. The pharmacy had a procedure for the team to follow when a person raised a complaint. 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 pharmacists completed regular balance checks of the CD registers to identify errors or missed entries. The team members correctly managed people's confidential information and they 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. Most of the regular pharmacists had completed 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's home reported any concerns about the person back to the pharmacy team. So, the team could take 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 receive some opportunities to complete ongoing training. But they don’t always receive individual feedback on their performance which means they may miss the chance to further develop their skills and knowledge.

Inspector's evidence

The previous pharmacist owner, the Superintendent Pharmacist and regular locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time dispensers who covered the day shifts and two part-time dispensers who covered the evening and weekend shifts. The team also included a full-time pharmacy apprentice and a delivery driver. One team member was the pharmacy supervisor who supported the pharmacists and organised team rotas and holiday cover. The pharmacy had arranged cover for the planned long-term absence of one of the dispensers. This was a pharmacy technician who was due to return from a planned long-term absence.

The pharmacy provided the team members with some additional training, but it didn’t provide formal performance reviews for them. So, they didn’t have the chance to receive individual feedback and identify opportunities to develop their knowledge and skills. The Superintendent Pharmacist provided training to team members when new services were introduced. The team members were knowledgeable on the recently introduced NHS hypertension case finding service. And they supported the pharmacists in providing the service including identifying people who would benefit from the service.

Team members worked well together and took opportunities such as the occasional team meetings to discuss different aspects of providing the pharmacy services and identify new ideas of working. There was usually some overlap between the day and evening shifts to enable key pieces of information to be shared amongst the team members. On other occasions they left notes for each other to ensure all team members were aware.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The dispensary was small but the team members managed the workflow to ensure there was sufficient space to work. And they kept the floor spaces in the dispensary clear to reduce the risk of trip hazards. The cleanliness of the premises was appropriately maintained and there were separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where items for sale were healthcare related. The pharmacy had an appropriately sized, soundproof consultation room which the team used for private conversations with people. The pharmacy premises were secure and the team restricted public access to the dispensary and rear areas during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible to people. And it manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. The pharmacy obtains its medicines from reputable sources and it generally manages and stores its medicines well. But the pharmacy doesn't always appropriately label and store some medicines as it should.

Inspector's evidence

The pharmacy provided its services until midnight Monday to Saturday and 8pm on a Sunday. The 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 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) and the information to be provided. The pharmacy did not have anyone prescribed valproate who met the criteria. The pharmacy had initiated the national serious shortage protocol (SSP) for prescriptions requesting the antibiotic penicillin V to ensure people received an appropriate alternate antibiotic medication.

The pharmacy provided multi-compartment compliance packs to help around 70 people take their medicines. To manage the workload the team members divided the preparation of the packs across the month. And they usually ordered the prescriptions in advance of supply to allow time to deal with issues such as items missing from the prescriptions. Each person had a record listing their current medication and dose times for the team to refer to when dispensing and checking the packs. 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 separate individual people's prescriptions and medicines from others and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found the team mostly completed both boxes. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. And it kept a record of the delivery of people's medicines for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources and team members generally followed the pharmacy's procedures to ensure medicines were safe to supply. This included marking medicines with a short expiry date to prompt them to check the medicine was still in date. And recording the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines remained safe to use. The team checked and recorded fridge temperatures and a sample of completed records found the readings were within the correct range. The team removed some medication from the original packs and transferred them to bottles and tablet boxes. However, several of the bottles weren't labelled with the batch number and expiry date of the medicine. This practice meant 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. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it used appropriate denaturing kits to destroy CDs. Since the last inspection the pharmacy had arranged for out-of-date CDs to be destroyed by the West Yorkshire Police CD liaison officer (CDLO). 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 and actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure its equipment is used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. It had appropriate equipment for the services provided including a large pharmacy fridge with a glass door that enabled stock to be viewed 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 positioned the dispensary computers in a way to prevent disclosure of confidential information. And the team members used cordless telephones to ensure their conversations with people were kept private. Completed prescriptions were stored way from public view 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.