General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The John Preddy Co. Ltd., 41-42 Moorland Road, BATH, Avon, BA2 3PN

Pharmacy reference: 1028560

Type of pharmacy: Community

Date of inspection: 13/01/2023

Pharmacy context

This is a community pharmacy located on a high street along a parade of shops, in Bath. It dispenses NHS and private prescriptions. And it offers a range of services for the local community including multi-compartment compliance packs for people who need them. The pharmacy also offers Covid-19 and flu vaccinations, a prescription delivery service, the NHS New Medicines Service, and it treats a range of minor illnesses using locally agreed contacts.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.6	Standard not met	The pharmacy doesn't keep all its records up to date as required. These include its records about fridge temperatures and controlled drugs.
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	4.3	Standard not met	The pharmacy does not have robust date-checking processes. It cannot show that it keeps medicines which require refrigeration at the right temperature. And it doesn't always keep medicines in containers which have the necessary information on the label. So, it cannot always be sure that the medicines are safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not keep all the records it needs to to be able to show it is providing safe and effective care to people. But its team members work within defined roles and responsibilities in an organised way. It has suitable insurance to cover its services. And its team members keep confidential information secure and know how to safeguard vulnerable people. The pharmacy could do more to use mistakes that happen as opportunities to learn and improve its services. It has not updated its written procedures for some time. So, its team members may not all be aware of current best practice.

Inspector's evidence

Standard Operating Procedures (SOPs) were in place at the pharmacy and covered a range of elements of the pharmacy's operation. But these were due for review in November 2022 and were 12 years old. So, the pharmacy team may not have been following the most up-to-date guidance when working. The Responsible Pharmacist (RP), who was a regular locum, had signed the SOPs to confirm they had read them. But other pharmacy team members had not signed these. So, it was unclear if the whole pharmacy team was aware of what procedures to follow when working. The RP explained that they would intervene if they identified a member of the team operating outside the SOPs and would explain the correct process to them. The pharmacy technician had a good understanding of the running of the pharmacy and was confident when completing tasks. And they were able to support other locum pharmacists working at the weekend. The pharmacy had a process to record errors which were identified before medicine were supplied to people (so called 'near misses'). But the record had not been completed recently and the last entry was in March 2022. This meant the pharmacy team may be missing out on opportunities to learn from errors and improve working practices. The RP showed evidence of two incidents in 2021 where the incorrect medicine was supplied to people (so called 'dispensing errors'). The pharmacy had investigated and recorded both incidents. In both instances the person who received the incorrect medicine received an apology and was involved in the investigation process. The pharmacy identified learning from both incidents to prevent the same thing happening again.

There was a RP notice displayed at the pharmacy. The RP explained that the team members were aware of what they could and could not do in the absence of the RP. And there was a SOP relating to this. There was also a SOP relating to the different roles and responsibilities of pharmacy team members. The pharmacy had a notice displayed outlining contact numbers for business continuity if needed.

There was a dedicated company email address for people to provide feedback, but the pharmacy team was not aware of a formal complaints policy. The RP explained if a person wished to complain the pharmacy team would apologise and offer the dedicated email address if required. A recent complaint was received which involved the delivery process. The RP apologised to the person who made the complaint and had implemented changes to the process as a result. The pharmacy had collected feedback from people who used their Covid-19 vaccination service and recorded this feedback on paper forms. It was notable that the pharmacy had received gifts such as biscuits and chocolates from people during the Christmas period as a thank you for the service it provided to the community. The pharmacy had appropriate professional indemnity and public liability insurance in place at the time of the inspection. And a certificate was displayed in the pharmacy to detail this.

The pharmacy kept records electronically and on paper. The fridge record was completed for one of the two fridges used by the pharmacy. It was explained to the RP that there needed to be records confirming the minimum and maximum temperatures for all fridges used in the pharmacy to store medicines. And that the temperature logs needed to be reset to ensure the data is accurate. The computer system the pharmacy used was able to record multiple fridge temperatures. And the RP confirmed they would record both fridges in future. Controlled Drug (CD) records were in paper form and organised into sections relating to each CD held. Entries were made in a timely fashion. But the RP said that they did not always complete a balance check in a timely manner. The RP explained openly that they were not able to complete balance checks recently due to focussing on other aspects of the pharmacy operation, but they recognised the importance of doing regular checks. The stock levels for a range of CDs were randomly checked during the inspection. One CD was found to have a discrepancy between stock held in the cabinet and the balance recorded in the CD register. This was highlighted to the RP who undertook to investigate immediately and report to the Accountable Officer if the discrepancy could not be resolved. The RP record was largely up to date. But there were some instances when the RP had not signed out at the end of their shift. Consultation records for clinical services provided by the pharmacy were recorded on a dedicated online platform. These were completed correctly, and a notification sent to GP surgeries where appropriate. Records about private prescriptions were largely completed correctly. But there were some entries which did not specify the details of the prescriber.

The pharmacy had a dedicated Information Governance folder which contained training records and company policies on protecting confidential information, including how long records needed to be retained. Computer terminals were password-protected, and the Patient Medication Record platform was also password-protected. The computer terminals were not visible to members of the public in the pharmacy. Team members used their own NHS smartcards, and each had a unique pin to gain access to NHS records. The online platform where consultation notes were stored was password protected. And other confidential information relating to people who used the pharmacy was stored appropriately. The RP and pharmacy technician had both competed level 2 safeguarding training. And other team members had completed level 1 safeguarding training. There was a list of local adult and child safeguarding team contact details for the pharmacy team members to refer to if they had any safeguarding concerns. The RP explained the process for supplying Emergency Hormonal Contraception which included a consultation with the person seeking the medication. The RP confidently explained key signs to watch out for which could highlight a potential safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are trained appropriately for the roles they undertake. And they have a good rapport. There are generally enough team members to manage the workload safely. The team can ask for help when needed. And targets do not compromise the team's professional judgement.

Inspector's evidence

At the time of the inspection there was one pharmacist who was a regular locum, two medicines counter assistants, one of which was a trainee, and a trained registered pharmacy technician. The team had a good rapport and seemed to work well together. There was no backlog in dispensing activity which showed there were enough team members to manage the dispensing workload. But some other key tasks were not always completed. The trainee medicines counter assistant was due to enrol onto an accredited training course. And the RP explained they would act as the supervisor to support the assistant in their development. The pharmacy technician explained that they would soon be beginning their accuracy checking course. The pharmacy technician provided evidence of Continual Professional Development (CPD) and had a dedicated folder with training certificates and reflective logs. Other team members accessed and completed mandatory

training via an accredited online learning platform. The RP explained that where possible, dedicated training time was provided during working hours.

The RP explained they felt confident to ask for help from the regional manager, who was also the pharmacy's Superintendent Pharmacist (SI). And all team members completed annual appraisals with the RP. There was a culture of openness at the pharmacy and the RP explained that they would feel comfortable raising concerns if they needed to. There were targets that the pharmacy was expected to reach for certain services. But the RP explained these were not always achievable. The pharmacy team members were able to explain to their manager the reasons for not achieving targets for services. They explained that the pharmacy team did its best to offer services to everyone who could benefit. The RP was clear that they did not offer services which were not clinically appropriate and that they were able to use their professional judgement without feeling pressured.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is appropriately secured against unauthorised access. And the premises are generally clean and tidy. But the pharmacy keeps some stock on the floor which may increase the risk of trips or damage to the stock.

Inspector's evidence

The pharmacy premises consisted of a ground floor unit on a parade of shops. The retail area was bright and professional in appearance with a window to the dispensary. There was a consultation room available for private discussions which was of a suitable size and could be locked. The dispensary area was generally clean. There was a logical flow to the workspace. And prescriptions were prepared and checked in separate areas. But there were some medicines stock on the floor which meant it could be damaged accidentally. There was hot and cold running water. But there was some discolouration around the tap at the sink. This tap had an intermittent drip which could be the cause. The RP agreed to highlight this to the maintenance department for investigation. The temperature and lighting were appropriate for providing pharmacy services. Soap was available for hand washing and cleaning measuring equipment. Patient-identifiable information was stored appropriately, and computer terminals were not visible to the public in the retail area of the pharmacy. The premises was appropriately secured from unauthorised access and access to keys was controlled. Controlled drug cabinets were securely fixed to the wall. Some areas of the ceiling were damaged from a recent leak from the premises on the first floor. The RP agreed to highlight this to the maintenance department.

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

Summary findings

The pharmacy generally prepares and supplies medicines safely to people. But it doesn't always date-check its medicines regularly, store them in appropriately labelled containers, or check that medicines stored in its fridges are kept at the right temperatures. This increases the risk that it could supply medicines to people which are not of the right quality. However, the pharmacy team members can identify people taking higher-risk medicines and know what checks to perform to make sure these medicines are taken safely. And the pharmacy has safeguards in place for when medicines are being delivered to people.

Inspector's evidence

The pharmacy was accessed via double doors from the main high street. And team members assisted people who needed help over the small step at the entrance. The pharmacy had a range of posters on the front window advertising the services available. And there was a notice on the front door which informed people that the pharmacist was unavailable during the lunch break. People were appropriately signposted to other providers for services the pharmacy did not offer.

The pharmacy team used initials to identify who had prepared medicines and who had performed the final check. This meant it was possible to see who was involved at each stage if a mistake was made. The pharmacy technician and RP were able to explain how to engage with people at higher risk of adverse effects from higher-risk medicines such as sodium valproate. This included asking the person if they had the valproate alert card and if they were prescribed appropriate contraception. The pharmacy technician had recently completed an audit of people who had valproate-containing medicines dispensed by the pharmacy. They were able to identify that no person was in the higher-risk categories.

The pharmacy team was aware of which people were regularly prescribed lithium. And there were stocks of lithium booklets along with steroid emergency cards and methotrexate booklets that the team could give to people prescribed these higher-risk medicines.

The pharmacy prepared multi-compartment compliance packs for people who needed them. The process was observed during the inspection. The team required written communication from prescribers for any changes to medicines within the packs. And a note was made on the person's medication record for the whole team to be aware of recent changes. A range of packs was randomly checked during the inspection. They had clearly printed sheets detailing the name of the medicine, its description, quantity, and directions for administration, along with contact details for the pharmacy and the identity of the person prescribed the medicines. The pharmacy team provided patient information leaflets for all medicines within the packs at the beginning of the month. And each pack was labelled with the week number so that future prescriptions could be ordered on time. The pharmacy technician explained that they regularly identified medicines which were not appropriate for these packs as people only took them when required. When these medicines were identified, the team confirmed with the prescriber that the medicines should be supplied in separate packaging.

The pharmacy team used a range of stickers to draw attention to prescriptions which required a conversation with the pharmacist, or those which contained medicines stored separately, such as fridge items. And there was a clear process for delivering medicines to people who could not collect them

themselves. The pharmacy team included two delivery drivers who used a diary to log which medicines were designated for delivery. The pharmacy technician explained that the drivers only delivered medicines to people who were at home. And they did not post medicines or leave them with someone else. This meant all medicines which were not delivered were returned to the pharmacy before the end of the day and were not stored in the delivery vehicles overnight. Medicines that required fridge storage were returned immediately following the failed delivery attempt. If not delivered, a card was left at the address advising people to arrange collection or a re-delivery by calling the pharmacy. The delivery drivers knew what to do if they identified a person who needed help during deliveries. On one occasion, a driver called the pharmacist to alert them to a person who was unwell. The pharmacist was then able to alert the person's GP and arrange help.

The pharmacy had a range of Patient Group Directions (PGDs) to supply prescription Only Medicines (POMs) to people who presented with defined conditions; these documents were kept in a folder. But some of these were out of date at the time of the inspection. An example was the PGD to treat a condition called impetigo. This PGD expired in February 2022 but was signed by the RP in March 2022. The inspectors explained to the

RP that valid PGDs needed to be in place for any services which used them. And expired PGDs could not be used to authorise the supply of POMs listed in them.

The pharmacy used a range of registered wholesalers to obtain medicines. And medicines waiting collection were stored appropriately in an area not accessed by the public. The pharmacy used two fridges to store medicines requiring refrigeration. But only one fridge had its maximum and minimum temperatures recorded. One of the fridges had a logged maximum temperature of over 17°C. And the RP could not provide assurance that this fridge was checked regularly. The RP agreed to record temperatures for both fridges in future. Several medicines were identified as past their expiry date when randomly checked in the pharmacy. The RP explained that the team aimed to check medicine expiry dates monthly. But the last record for this was April 2022. This created a risk that out-of-date medicines could be supplied to people without knowing. Some medicines were removed from the manufacturer's packaging and stored with no record of their batch numbers or expiry dates. This meant that the team would not be able to identify if these medicines had expired or were subject to a recall or a safety alert. The pharmacy stored Controlled Drugs (CDs) securely and unauthorised access was prevented. The pharmacy team received alerts relating to medicines from the MHRA and had a process to act on these. A range of printed alerts were seen during the inspection, and each had the date which it was actioned on, and a copy was sent to the pharmacy's head office for reference. Medicines were disposed of appropriately and the pharmacy had appropriate arrangements for disposal of needles relating to vaccination services.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team members can access up-to-date information to help them provide services safely. And the pharmacy has the equipment it needs to deliver the services it offers. But it could do more to make sure its measuring equipment is kept clean to prevent cross-contamination.

Inspector's evidence

The pharmacy used validated glass measures to measure liquid medicines. And it had separate measures for medicines associated with higher risk. There were several tablet counters and a dedicated one used for cytotoxic medicines. Some glass measures looked unclean, and some tablet counters appeared dusty. This was highlighted to the RP during the inspection who agreed to make sure these were cleaned more regularly in future. The pharmacy team members had online access to appropriate reference sources and were able to use personal phones to use these reference sources in the event of the internet connection failing at the pharmacy. There were cordless phones so team members could take calls from people using the pharmacy in private areas. There were two fridges used to store medicines and these were appropriately clean. And there was new equipment to measure blood pressure.

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.