General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: SAI Dutt Ltd, 342 Wellington Street, GRIMSBY, South Humberside, DN32 7JR

Pharmacy reference: 1032492

Type of pharmacy: Community

Date of inspection: 17/06/2021

Pharmacy context

This community pharmacy is in a large estate close to Grimsby Town Centre and it changed ownership in December 2019. The pharmacy's main activities are dispensing NHS prescriptions and delivering medication to some people's homes. The pharmacy supplies medicines in multi-compartment compliance packs to help several people take their medicines. The pharmacy provides the NHS COVID-19 vaccination service. The pharmacy was inspected during the COVID-19 pandemic.

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 including the risks from COVID-19. It has up-to-date written procedures that the pharmacy team follows. And it mostly completes all the records it needs to by law. The team members demonstrate an understanding of their role in helping safeguard the safety and wellbeing of children and vulnerable adults. And they respond promptly when concerns arise. The pharmacy team members respond adequately when errors occur. They discuss what happened and they take suitable action to prevent future mistakes.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments for all team members to identify their personal risk of catching the virus. The pharmacy had installed plastic screens on the pharmacy counter to provide the team with extra protection. The retail area provided space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The pharmacy had hand sanitisers available in different sections of the retail area for people to use. The dispensary size enabled team members to mostly adhere to social distancing requirements. And they wore Personal Protective Equipment (PPE) masks and aprons. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and many tests had been supplied.

The pharmacy had a range of up-to-date standard operating procedures (SOPs). The SOPs provided the team with information to perform tasks supporting the delivery of services and described the roles and responsibilities of team members. Some SOPs named the pharmacy whilst others only had the name of the organisation who had developed the SOPs. Some team members had read and signed the SOPs signature sheets to show they understood and would follow them. However, the signatures were not dated to show they were recent and reflected the updated SOPs. 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.

The Superintendent Pharmacist (SI) had created a separate SOP for the COVID-19 vaccination service. And a separate list detailing the roles and responsibilities of team members supporting the service. The SI had also completed a detailed risk assessment of the COVID-19 vaccination service as part of the pharmacy’s preparation for providing the service. The SI had attended a vaccination site close by to observe how it operated. And had involved the team with a mock-up of the service and the person's journey to get feedback and suggestions from all team members. One team member had asked how the pharmacy would achieve the number of vaccines asked by the NHS. This triggered the SI to pull together a timetable of when the vaccination service would be provided and how many trained vaccinators would be available.

The pharmacist or accuracy checking technician (ACT) when checking dispensed prescriptions and spotting an error informed the team member of the error rather than inviting them to find it themselves. The pharmacy kept records of these errors known as near miss errors. The pharmacist or ACT rather than the team member involved created the record. This meant the team member didn’t have the opportunity to record their thoughts on the cause of the error and how to prevent the error

from happening again. The team could not initially locate the near miss record and when it was found it showed the last entry was made in March 2021. The record had sections to record learning points and actions taken to prevent the error from happening again. A sample of records showed some learning but no details of the actions taken by the team to prevent the error from happening again. A few entries referenced the constant ringing of the telephone as a factor that caused the error which was described as a distraction. The team explained the number of incoming phone calls had increased since the COVID-19 vaccination service started. Most of the calls were from people asking about their bookings made through the NHS national booking system. The team discussed whether a voicemail could be set up to provide people with information about the COVID-19 vaccination service or direct them to another number before the call came through to the pharmacy team. There were no telephones in the room where the team members dispensed compliance packs as the team identified this could be a distraction. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. This included reporting the error and sharing it will all team members so everyone was aware and could learn from it. The pharmacy displayed a list of medicines that were often involved in errors. The team members used this information as a prompt to check the item they had selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A leaflet provided people with information on how to raise a concern with the pharmacy team. The pharmacy received positive comments from people who had used the COVID-19 vaccination service.

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 mostly met legal requirements. The RP record had a few missed entries. A sample of records for the receipt and supply of unlicensed products found they didn't meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The details of the person the medication was supplied to were not recorded. A concern had been raised with the GPhC about the pharmacy's compliance with the legal requirements for CD registers. The pharmacy trained the technicians and dispensers to complete the CD register entries. This was one of the daily tasks allocated to a team member who had protected time to complete the entries. Completed CD prescriptions were kept in a dedicated section awaiting entry into the CD register. The dispenser listed the CDs from each prescription and with the pharmacist checked the balance of the CD stock before making the entries. The dispenser crossed each CD off the list as the entry was made. The team member allocated the task checked the section holding completed CD prescriptions at the end of the day to ensure there were no outstanding prescriptions. A sample of CD registers found they complied with the legal requirements. The pharmacy had procedures for managing confidential information and the team was aware of the requirements of the General Data Protection Regulations (GDPR). The pharmacy displayed a 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 completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team responded well when safeguarding concerns arose. The delivery drivers reported to the pharmacists any concerns they had about people they delivered to. The pharmacist then took appropriate action such as contacting the person's GP. The team members were aware of the Ask for ANI (action needed immediately) initiative. But they had not had the occasion to offer it.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large experienced team with the qualifications and skills to support its services. Team members work very well together. They support each other in their day-to-day work, especially at times of increased workload and when the pharmacy introduces new services. The team members discuss ideas to enhance the delivery of the pharmacy's services and they benefit from identifying areas of their own practice they wish to develop. Pharmacy team members receive some informal feedback on their performance and they have some limited opportunities to complete ongoing training. This means they may find it harder to keep their knowledge and skills up to date.

Inspector's evidence

The Superintendent Pharmacist (SI) and regular locum pharmacists covered the opening hours. The pharmacy employed around 20 team members including two part-time pharmacy technicians, a part-time trainee technician, a full-time dispenser recently employed as the pharmacy manager, full-time and part-time dispensers, part-time medicine counter assistants (MCAs). And two part-time delivery drivers. The MCAs were trained to order repeat prescriptions especially for the service providing compliance packs. One of the MCAs had also been trained on putting medicinal stock away. At the time of the inspection eight team members were on duty. The pharmacy had a separate team supporting the delivery of the COVID-19 vaccine service. This team included a full-time administrator who booked people in. And volunteers acting as marshals who met people at the pharmacy entrance and directed them where to wait if attending for the vaccination service or to the pharmacy counter for other services. The SI was the main vaccinator, several other trained vaccinators were available to support the service when required. The pharmacy employed one of the regular locum pharmacists when the SI was providing the vaccination service.

The recently recruited pharmacy manager was previously the pharmacy supervisor and had expressed an interest in stepping up to the role of manager. The new manager spent some time with the SI discussing the position and asked to be enrolled on to a training courses that would support their development in the role. The manager discussed her initial ideas on implementing changes to the pharmacy systems with team members before progressing with the changes.

The pharmacy had a rota of daily tasks for the team members to complete. One of the pharmacy technicians was responsible for setting the rota of tasks each week. And tasks were allocated to different team members each day. This ensured the tasks were completed and made sure all team members knew how to do the tasks. The tasks included putting stock away and completing prescriptions with owings. The pharmacy was trialling a buddy system to support the team in the completion of tasks. This would enable team members to ask the colleague acting in the role of the buddy for help in completing their allocated task. The team identified the importance of the buddy role especially when team numbers were reduced due to absences or if the team's workload increased.

The team members occasionally had access to online training modules to keep their knowledge up to date. The team members had some protected time to complete the training. The pharmacy did not provide formal performance reviews for the team members. This meant there was limited chance for team members to identify their training needs and discuss their development needs. The team members occasionally received informal feedback. The pharmacy sometimes held team meetings but

due to the team members' work patterns not everyone could attend. The pharmacy used a social media group to ensure all team members had up-to-date information such as changes to pharmacy procedures. The pharmacy manager recently set up a suggestions box to capture team members ideas or comments on the pharmacy systems. This had not been used at the time of the inspection but team members reported they liked this method of getting feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. During the pandemic the team regularly cleaned the pharmacy and used separate sinks for the preparation of medicines and hand washing. The team kept floor spaces clear to reduce the risk of trip hazards and there was enough storage space for stock, assembled medicines and medical devices. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy restricted access to the dispensary during the opening hours. The pharmacy had a large, soundproof consultation room used for private conversations with people. The pharmacy had a separate, cordoned off section that provided privacy to people receiving their medication as a supervised dose. And for people using the needle exchange service.

The pavement outside the pharmacy was divided into two clearly marked sections for people who were presenting for the COVID-19 vaccination service or other pharmacy service. This meant people who were queuing for the services were socially distanced from each other. The team split the retail area in the pharmacy into two sections. One for people waiting for the COVID-19 vaccination service and the other for people presenting at the pharmacy counter for other services. A small section of the retail area away from the pharmacy counter had been converted into the vaccination station. The team cleaned the vaccine station and the plastic chairs in the waiting area after each person had received the vaccine. NHSE had provided the pharmacy with screens to use at the vaccination station to provide privacy to the person receiving the vaccine.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. It supports the team to address any identified issues to make sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had been providing the COVID-19 vaccination service for a few months and it was a popular service. Most people presenting on the day of the inspection were receiving their second dose. People were greeted by one of the marshals who, after confirming the person had an appointment, directed them to the waiting area where another team member checked the person in. The chairs in the waiting area were spaced to meet the social distancing requirements. The SI spent time with people who were slightly anxious about receiving the vaccine before they agreed to receive it. People receiving the vaccine were advised to wait in the car for 15 minutes before driving off. The SI had developed a guide for the team to follow when a person became unwell. This included the marshals advising people to make one of the team aware as soon as they started to feel unwell. The SI had created an information leaflet to give to people about how they could give feedback about the vaccination service.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. The manager had changed the process of ordering prescriptions to two weeks from one week and introduced a filing system to help the team know which prescriptions had to be requested. Two team members were responsible for ordering prescriptions, tracking the receipt of the prescriptions and chasing up outstanding requests. The team stored received prescriptions in a box file in date order so all dispensers knew which prescriptions to dispense first. One dispenser picked the stock needed for the prescription and placed it in a basket with the prescription. A second dispenser checked the stock picked before dispensing the medication into pack. The team used a dedicated room away from the distractions of the busy retail area to dispense the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer’s patient information leaflets. This meant people could identify the medicines in the packs and had information about their medicines. Completed packs were stored on dedicated shelves labelled with the person’s name.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacy team prepared the doses in advance of supply to reduce the workload pressure of dispensing at the time of supply. The team used a measuring pump to prepare the doses. This was regularly cleaned and checked for accuracy to ensure the correct doses were supplied. The pharmacy stored the prepared doses securely and separated different people’s doses to reduce the risk of picking the wrong one. The team bagged multiple doses for the same person together in a clear bag. The team kept a record of communications between the pharmacy and the prescribing team. This ensured everyone in the team was aware of any received information about a person such as a dose change. The team protected people’s privacy when they presented for their dose by writing the person’s name and date

of birth on a piece of paper and placing it in a dedicated plastic wallet. The team member called out that a blue basket was waiting. This meant the team in the dispensary was aware that a person had presented without their name being revealed to other people waiting in the pharmacy. The team had a similar system for people presenting for the needle exchange service except the call-out code was a yellow basket. The team provided people with clear advice on how to use their medicines. The team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had PPP information to provide to people when required. The pharmacy currently didn't have anyone prescribed valproate who met the criteria.

The pharmacy provided 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 looked at found that the team completed the boxes. The pharmacy had additional records to capture the different team members involved in the dispensing and checking of the compliance packs. And the dispensing and checking of prepared doses of supervised medication. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. Two team members were responsible for preparing completed prescriptions for delivery. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 the delivery drivers did not ask people to sign for receipt of their medication.

The pharmacy obtained medication from several reputable sources. The pharmacy manager had recently rearranged the stock on the shelves so it was easier to locate. The pharmacy team checked the expiry dates on stock and kept a record of this but it was not available at the time of the inspection. 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.

A concern had been raised with the GPhC about the use of medicines returned to the pharmacy. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. The team members took appropriate action when a person's medication was returned to the pharmacy. And promptly placed the medication into the medicinal waste bins. No evidence was found of the re-use of medication returned to the pharmacy. The pharmacy 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) via email. The team usually printed off the alert, actioned it and kept a record.

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 sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had a range of CE equipment to accurately measure liquid medication. The pharmacy had two fridges to store medicines kept at these temperatures. The fridges 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 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 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.