General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Asif Iqbal Pharmacy Ltd.;, 70 St. Helens Road, BOLTON, Lancashire, BL3 3NP

Pharmacy reference: 1033188

Type of pharmacy: Community

Date of inspection: 14/06/2022

Pharmacy context

This community pharmacy is located on a main road on the edge of the town. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines.

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	1.1	Standard not met	The pharmacy does not have adequate standard operating procedures for the services it provides.
		1.6	Standard not met	Records are not always accurate and the CD register is not kept on the pharmacy premises.
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 appropriately manage and organise its stock medicines including controlled drugs. It does not have a robust date checking procedure and some of its stock medicines are not stored in their original packaging with batch numbers and expiry dates. And the pharmacy does not properly restrict unauthorised access to some of its medicines.
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 adequately manage risks. The pharmacy's written procedures are not regularly reviewed, so there is a risk that pharmacy team members may not work effectively or fully understand their roles and responsibilities. The team members do not always record or review their mistakes, so they may be missing out on some learning opportunities. The pharmacy's records are not always available and accurate, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided. But most of these had been prepared between 2007 and 2013 and had not been reviewed since. Some of the SOPs had not been signed by current members of the pharmacy team to indicate they had read and accepted them. The dispenser, who was a director, said he could not remember when he had last read them. There were two different versions of some SOPs and it was not clear which was the current version. Some SOPs required under the responsible pharmacist (RP) regulations were missing and some of the SOPs were not being closely followed. For example, assembling compliance aids and controlled drug management. So, team members may be unclear of the procedures, their roles and responsibilities and who is accountable for what. The dispenser was able to describe his duties which were in line with his role and level of training. But he did not wear a uniform or name badge showing his role, so this might not be clear to members of the public, and he had on occasions been mistaken for the pharmacist. The superintendent pharmacist (SI) was working as the responsible pharmacist (RP) and his name was displayed as required by the RP regulations.

The pharmacy team had written procedures for recording dispensing incidents and near misses, but these were not being followed and the SI was not able to demonstrate that any previous dispensing errors had been recorded. The SI explained that he was dealing with a recent error when a patient had received the incorrect strength of ramipril. He said he had contacted the patient's GP and there had been no harm caused. He had checked the dispensary shelves and the different strengths of ramipril were clearly separated. The team had reflected on the error and believed it might have been because it had been assembled last thing on Friday evening, and the team may have been rushing. The SI had not yet reported the error but confirmed that he would report it online on the national reporting learning system. There had been no near misses recorded since 2016, so opportunities to identify and mitigate risks may be missed. The SI said he discussed errors with the dispenser and made changes to avoid re-occurrences. He could not recall the team making any recent changes.

There was a complaint procedure, but there was nothing on display in the pharmacy to inform people how to raise concerns or leave feedback. The dispenser said he could not recall any complaints and the pharmacy team usually received positive feedback. For example, a family who had moved outside the area still used the pharmacy because of their good customer service.

Insurance arrangements were in place. Private prescription records were maintained electronically, but some details had not been entered accurately. The name of the prescriber and the date of the prescription was incorrect on one entry, and some NHS prescriptions and over-the-counter sales had

been recorded as private prescriptions. The time at which the RP commenced their duties on the RP log was usually recorded after 9am. For example, 9.18am on the morning of the inspection, which was after the pharmacy had opened. The SI explained that the time recorded on the log was the time the pharmacy's computer was signed on, rather than the time he commenced his duties as RP at the pharmacy. These inaccurate records could cause confusion in the event of a problem or query. The controlled drug (CD) register was not on the pharmacy premises. The SI said he had taken it home to update it, but he had forgotten to bring it back on either of the following two working days. This meant the CD register was not available for inspection and the pharmacy team were not able to make entries in the CD register, which was a breach of CD regulations. The following day the SI confirmed that the CD register was back on the pharmacy premises and forwarded photographs of it. There was a designated book to record the return and destruction of patient returned CDs, but none had been recorded since 2011.

There was an information governance (IG) file which included details about confidentiality. Confidential waste was collected in a designated place. The shredder had broken, so the SI took the confidential waste home and incinerated it. This potentially risked breaching patient confidentiality, although the SI said he took care that the waste was protected until he had fully incinerated it. The dispenser correctly described the difference between confidential and general waste. Assembled prescriptions were stored appropriately so that people's details could not be seen by members of the public. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR).

The SI had completed level 2 training on safeguarding children and vulnerable adults. It was not clear if the dispenser had carried out any formal training on safeguarding, as there were no records of this, and the dispenser could not remember. So, there was a risk that he might not be able to identify problems or know how to deal with them. There was a safeguarding policy and some guidance in place containing the contact numbers of who to report concerns to. However, this had not been updated for many years so might not contain the correct details, which might result in a delay to a concern being raised. The pharmacy had a chaperone policy. There was a notice highlighting this, however, it was displayed in an area which was not normally accessed by the public, so people might not realise this was an option. The SI was aware of the 'Safe Space' initiative, where pharmacies were providing a safe space for victims of domestic abuse, but he had not registered the pharmacy to take part in it.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications for the jobs they do and they have the opportunity to discuss issues informally. But team members do not get regular ongoing training, so there may be gaps in their knowledge and skills.

Inspector's evidence

The SI and an NVQ2 qualified dispenser were on duty at the time of the inspection. There were also two part time delivery drivers on the pharmacy team. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the people who visited the pharmacy. There was a medicines counter assistant (MCA) who had previously worked at the pharmacy and could help out when required.

The team was small so issues and concerns were discussed informally as they arose. There was no formal appraisal system to discuss team members performance and development. The dispenser and MCA were appropriately qualified and their certificates on display. But there was no record of any ongoing training, so their knowledge might not be fully up-to-date. The SI was able to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. There was no pressure on the team to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations. But there are some outstanding maintenance issues which affect the working conditions and detract from the professional image of the pharmacy.

Inspector's evidence

The pharmacy premises were in an adequate state of repair. The retail area was free from obstructions, but the medicines counter had been moved forward during the pandemic, and the layout and customer flow around the pharmacy was confusing. Some ceiling tiles had been removed to carry out some maintenance work. The floor was heavily marked and the dispenser said it was difficult to clean. Parts of the pharmacy were untidy which compromised the professional image. The temperature and lighting were adequately controlled. There was a WC with a wash hand basin and a separate dispensary sink for medicines preparation, but there was no running hot water. The dispenser explained there was a kettle to provide hot water if necessary. Hand sanitizer gel was available. There was a large consultation room with several chairs. This could be used when customers needed a private area to talk. The sign which highlighted the availability of the room had fallen down and had not yet been refixed.

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

Summary findings

The pharmacy offers a small range of healthcare services which are generally well managed and easy for people to access. The assembly of multi-compartment compliance aid packs is reasonably well organised. But some people might not always have easy access to all of the information they need to take their medicines safely. The pharmacy gets its medicines from licensed suppliers but it does not always organise and manage stock medicines appropriately to make they are in good condition and safe to use.

Inspector's evidence

There was a step up to the front door of the pharmacy, but it was possible for customers to enter with prams and wheelchair users with assistance. The SI said he would always be ready to serve customers at the door if necessary. There was a range of healthcare leaflets and a couple of posters advertising local services. The display of leaflets was untidy and some of the material was out of date. For example, there was a poster advertising free lateral flow tests, which had ceased. The pharmacy offered a small range of services. A folder was available containing signposting information which could be used to inform people of services and support available elsewhere. The staff were multilingual speaking Urdu and Gujarati which assisted most of the non-English speaking patients from the local Asian community. There was a home delivery service with associated audit trails. A high proportion of prescriptions were delivered. The service had been adapted during the pandemic to minimise contact with recipients. The delivery driver stayed a safe distance away whilst the prescription was retrieved from the door-step, and then confirmed the safe receipt in their records. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was very limited in the dispensary, and there was insufficient bench space. Lids from wholesaler's tote boxes had been placed over the sink area to make more space available. There was a designated checking area. Dispensed by and checked by boxes were generally initialled on the medication labels to provide an audit trail. Baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. Some of these baskets had been stacked on the floor due to insufficient bench space, which was unhygienic and a tripping hazard. Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. The SI was aware of the valproate pregnancy prevention programme. He said none of their regular patients were in the at-risk group. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Multi-compartment compliance aid packs were managed electronically using the patient medication record (PMR) software system. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these, which could cause confusion in the event of a problem. A dispensing audit trail was not completed, which might limit learning if there was an error. Medicine descriptions were not added to the compliance pack labels, and packaging leaflets were not usually included. So, people might not be able to identify the individual medicines or have easy access to all of the information they need. And this was not in line with the SOP. Disposable equipment was used. The SI competed an assessment as to the appropriateness of a pack or if other adjustments might be more suitable to their needs when new people requested a compliance aid pack.

The dispenser explained what questions he asked when making a medicine sale and knew when to refer the person to a pharmacist. He was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

The CD cabinet was not securely fixed to the wall. It was very full and one packet of morphine sulphate ampoules 10mg/ml was in a basket on top of the cabinet, which risked unauthorised access. The SI said it had been placed there ready for a prescription, but it hadn't arrived. There was a large quantity of patient returned CDs in the cabinet, which had been returned to the pharmacy but had not been recorded in the designated book. A denaturing kit was available for the destruction of CDs. The CD cabinet contained paperwork, which did not need to be stored in the cabinet and took up valuable space. The CD keys were under the control of the responsible pharmacist during the day. Pharmacy (P) medicines and prescription only medicines (POMs) were stored behind the medicine counter but there were no barriers and people could move freely around the counter risking unauthorised access. Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials'.

The dispenser confirmed he carried out date checking on a regular basis, but this was not documented, so some areas of the dispensary might be missed. Dates had not been added to opened liquids with limited stability. The dispenser said he knew they had only been opened within the last week or two and said the remainder would be dispensed the following week. There was a large number of medicines which were not in their original container and were on the dispensary shelves in foil strips without appropriate labelling. Some of the strips did not contain the medicine's batch number or expiry date, so team members would not know if they had expired. Expired and unwanted medicines were segregated and placed in designated bins.

The pharmacy received alerts and recalls via email messages from the PSNC. The SI said these were read and acted on but a record of the action was not made, so the team would not easily be able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The SI used an App on his mobile phone to access the current versions of the British National Formulary (BNF) and BNF for children for reference BNF. There was a small medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in working order. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had a tablet triangle for counting loose tablets. The dispenser said he would wear disposable gloves and clean the triangle thoroughly after counting cytotoxic drugs on it. He said most cytotoxics were obtained in foil strips, so there was no need to handle them. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.