General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Udani Pharmacy, 22-24 Queens Drive, LIVERPOOL, Merseyside, L15 7NE

Pharmacy reference: 1034574

Type of pharmacy: Community

Date of inspection: 08/01/2020

Pharmacy context

The pharmacy is situated amongst a small number of other retail shops, in a residential area of Liverpool. The pharmacy premises are accessible for people, with adequate space in the retail area. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. It has a consultation room available for private conversations and to provide some services. And it supplies medication in multi-compartment compliance aids for some people, to help them take the medicines at the right time. The pharmacy provides a prescribing service for some people. And It has two pharmacist independant prescribers. The prescribing service is available for the following clinics and conditions, an aesthetics clinic, erectile dysfunction, hair loss, weight loss, hyperhydrosis (excess sweating), travel vaccinations, malaria prophylaxsis and obtructive sleep apnoea.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which are then incorporated into day to day practice to help manage future risk.
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 has written procedures to help make sure the team provide services effectively. And it protects peoples' information. Members of the pharmacy team are clear about their roles and responsibilities. They record their mistakes so that they can learn from them. And act to help stop the same sort of mistakes from happening again.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) for the services provided, with sign off sheets showing that members of the pharmacy team had read and accepted them. Roles and responsibilities of the pharmacy team were set out in SOPs. A member of the pharmacy team was able to clearly describe her duties. Dispensing incidents were recorded on incident report forms and reviewed by the superintendent (SI). Near miss errors were discussed with the member of the pharmacy team at time of the error and were reviewed by the accuracy checking pharmacy technician (ACPT) each month for trends and patterns, with the outcome of the review shared with the team. The pharmacy had set up a WhatsApp group for the team to discuss and share dispensing errors. The sertraline medication stock and sildenafil medication stock had been placed on different dispensary shelves, due to there previously being several near miss errors when team members had dispensed these medicines. The SI was an independent prescriber (IP) and was prescribing on private prescriptions on the premises for some people. When questioned, the SI said that he had not yet read the GPhC guidance for pharmacist prescribers but he provided assurance that he would do so, in order to help mitigate the risks associated with prescribing.

The correct responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy. A complaints procedure was in place. But details about it were not on display so people may not always know how they can raise concerns. The pharmacist explained that he aimed to resolve complaints in the pharmacy at the time they arose. A customer satisfaction survey was carried out annually with the results of the last survey displayed. The pharmacist explained that some people had provided negative feedback about the stock availability of certain medication. He said the pharmacy had a good working relationship with the local GP practice and the GPs would change the medication prescribed when there were manufacturing problems with specific medication.

Insurance arrangements were in place. And a current certificate of professional indemnity insurance was present. The private prescription record, emergency supply record, unlicensed specials record and the electronically held CD register were in order. Patient returned CDs were recorded appropriately. A balance check for a random CD was carried out and found to be correct. The responsible pharmacist (RP) record was up-to-date but had the time the RP ceased their duty missing on some occasions.

Confidential waste was shredded. Confidential information was kept out of sight of patients and the public. An information governance policy was in place and all staff had read and signed confidentiality agreements as part of their training. The computers were password protected with screens facing away from the customer and assembled prescriptions awaiting collection were stored in a manner that protected patient information from being visible. There was no privacy notice displayed. So, people may be unaware how the pharmacy intended to use their personal data.

The pharmacist and ACPT had completed level 2 safe guarding training and all team members had read the safeguarding policy. The local contact details for raising a concern were present for the team to refer to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. The team members are trained and work effectively together. They are comfortable about providing feedback to the pharmacist and receive feedback about their own performance. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was the superintendent pharmacist (SI), a pre-registration trainee, an accuracy checking pharmacy technician (ACPT), a dispenser, a trainee medicines counter assistant, a team member who had been enrolled on the NVQ2 course to become a dispenser but the deadline for completing the course had now lapsed and a delivery driver on duty. When questioned, the pharmacist explained that the team member whose training had lapsed was leaving their employment in February and he provided assurance that they would not be involved in any dispensing activity up until they left their employment. The trained team members had completed accredited training courses for their roles and their certificates were displayed. The team were busy providing pharmacy services. They appeared to work well together and were able to manage the workload adequately.

When questioned, a member of the pharmacy team spoken to said the SI was supportive and was more than happy to answer any questions they had. Training records for all team members were present. The member of the pharmacy team had completed online training modules on an ongoing basis. The pharmacy team members received an annual appraisal with the SI. A member of the team explained that the appraisal was useful, and it was an opportunity for her to provide and receive feedback on her performance during the last year. The pharmacy team were aware of a process for whistle blowing and knew how to report concerns if needed. They were regularly given information from the pharmacist. For example, about near miss errors or training modules due to be completed.

The trainee medicines counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as co-codamol, which she would refer to the pharmacist for advice. The pharmacist explained that there were no formal targets set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally tidy. It is a suitable place to provide healthcare. And it has a consultation room so that people can have a conversation in private or receive some of the pharmacy's services.

Inspector's evidence

The pharmacy was clean and generally tidy. It was free from obstructions and had a waiting area. Dispensary benches, the sink and floors were cleaned regularly, and a cleaning rota was displayed. The temperature in the pharmacy was controlled by heating units. Lighting was adequate.

The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were reported to the pharmacist and dealt with. Pharmacy team facilities included a microwave, fridge, kettle, toaster, WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was uncluttered and clean in appearance. It was used to provide the private services such as aesthetics, travel vaccinations, weight loss, erectile dysfunction and hair loss. It had a clinic treatment chair for people.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people. And they are generally well managed, so people receive their medicines safely. But the pharmacy does not keep full records of consultations for the prescribing service. So it may not be able to demonstrate the reasoning behind prescribing decisions. It stores most of its stock medicines appropriately. But some re-packaged medicines are not adequately labelled, which could cause errors to happen.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a selection of healthcare leaflets. The pharmacy team were clear about what services were offered and where to signpost to a service if this was not provided. For example, needle exchange. The opening hours and a list pf services provided were displayed near the entrance.

The work flow in the pharmacy was organised into separate areas, with a designated area for dispensing the multi-compartment compliance aid packs, adequate dispensing bench space and separate checking areas for the pharmacist and ACPT. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

Prescriptions containing schedule 2 CDs had a sticker included on the assembled prescription bag. This was to act as a prompt for team members to take the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. Prescriptions containing schedule 3 and 4 CDs were not routinely highlighted. This meant there was a possibility of supplying a CD on a prescription that had expired. A member of the pharmacy team explained that prescriptions with high-risk medicines such as warfarin, methotrexate or lithium were not routinely highlighted prior to collection. So, the team may not always make extra checks or give people advice about how to take them.The pharmacy was in the process of carrying out an audit for people prescribed valproate and had identified one person who met the risk criteria, who was to be reviewed by the pharmacist. The pharmacy had no patient information resources for the supply of valproate, which meant they may not be able to supply all of the necessary information if valproate was dispensed.

A member of the pharmacy team provided a detailed explanation of how the multi-compartment compliance aid service was provided. The service was organised with an audit trail for changes to medication with the handwritten list of medicines and the computer patient medication record (PMR) being updated. Disposable equipment was used. Individual medicine descriptions were not always added to each compliance aid pack. So, people may not be able to easily identify their medicines. Patient information leaflets were included.

The pharmacy provided an influenza vaccination service for private and NHS patients. The up to date, signed patient group directive (PGD) and SOP were present. The pharmacist explained how the influenza vaccination service was provided to people, which was in accordance with the SOP and PGD. The pharmacy had the necessary equipment for providing the service, including, in-date influenza vaccinations, in-date adrenaline ampoules, swabs, sharps bin, hand sanitising gel and consent forms.

The pharmacy had a prescribing service that was carried out by the SI and a second part-time pharmacist who worked on a Saturday. Both pharmacists were independant prescribers. Upon questioning, the pharmacist explained that both he and the other pharmacist independant prescriber had personal indemnity insurance cover to carry out both the prescribing and the practitioner role for each of the private services provided. He said the other pharmacist was not involved with any aspect of the aesthetics clinic, including, prescribing or the practitioner role. The pharmacist explained that people only accessed the prescribing service by attending the pharmacy and being reviewed in the consultation room. He said people were able to book appointments for the travel vaccination service online, and other prescribing services were arranged by people telephoning the pharmacy. He said the prescribing service did not involve any online prescribing and a review of the website confirmed this. The list of conditions or clinics that the prescribing service was available for included, influenza vaccinations, aesthetics, erectile dysfunction, hair loss, travel vaccinations, malaria prophylaxsis, obstructive sleep apnoea, hyperhydrosis and HPV vaccination. The pharmacist said that he prescribes and clinically checked the prescriptions he produced for the prescribing service, with the dispensing and accuracy checking of the prescription carried out by another member of the pharmacy team. He said that people using the prescribing service were not routinely given the choice to use another pharmacy and this was because of the nature of the medicines or treatment being provided. He explained that both he and the other pharmacist independant prescriber had access to the NHS summary care record (SCR) for people using the prescribing service, but said he had not acccessed SCR for the prescribing service to-date. He said that detailed medical histories were taken from people using the prescribing service as part of the face-to-face consultation process. He said consultation documentation for the travel service and aesthetics service was kept and he also added consultation notes to some of the private prescriptions for other people using different aspects of the prescribing service. The pharmacist said he did not routinely keep records for all decision making, but he had made a record when he had refused to supply treatment for weight loss to a patient because their BMI was too low. He said that people who received any form of vaccination treatment through the prescribing service were asked if they were happy for the details of the vaccination to be shared with their GP and if they provided consent, the GP was sent an email through the NHS email platform, advising them of the treatment provided. He said people using any of the other prescribing services such as aesthetics had no information shared with their GP. The pharmacist explained that people who accessed the aesthetics clinic or weight loss clinic were followed up by him and were provided with his contact details in case of an issue or advice being sought when the pharmacy was closed.

The pharmacy's private aesthetic service was provided to some people. The pharmacist explained that he had received training to provide the aesthetics service from a local dentist who was trained and that the training had included a mentorship over the last year. He said that both he and the dentist who trained him were members of the Aesthetic Complications Expert (ACE) group. The pharmacist had received accreditation in January 2018 from an organisation whose national register of practitioners was accredited by the professional standards authority (PSA). The pharmacist explained how the service was provided to people and said that he prescribed the required treatment on a private prescription. Detailed consultations took place between the pharmacist and patient, with copies of these kept. Signed and dated consent for treatment was gained from patients. Botulinum stock was sourced from licensed wholesalers. The necessary equipment needed to provide the service was present, including, sharps bin, in-date botulinum, in-date dermal fillers, sterile needles, adrenaline ampoules and swabs.

Stock medications were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock was generally stored tidily. Some stock medicines had been removed from their original packaging and placed into containers that had no batch number or expiry date details on. So, the pharmacy was not complying with labelling requirements and this practice may lead to supplying a medicine that was not safe or fit for purpose. These stock medicines were disposed of by the

pharmacist at the time. Date checking was carried out and a record was kept. One out-of-date stock medicine was present from a number that were sampled, and this was disposed of appropriately. Patient returned CDs were destroyed using denaturing kits and a record was kept. There were three clean fridges for medicines, equipped with thermometers. The minimum and maximum temperatures were being recorded daily and the records were complete.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). It had FMD software installed and a 2D barcode scanner. But the team were not decommissioning FMD compliant medicine packs prior to supply. Therefore, the pharmacy was not yet complying with legal requirements. Alerts and recalls were received via NHS and MHRA email. These were actioned on by the pharmacist or pharmacy team member and a record was kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. It is used in a way that protects privacy. And electrical equipment is regularly tested to make sure it is safe.

Inspector's evidence

The pharmacy had copies of the up to date BNF and BNFc. The pharmacy team used the internet to access websites for up to date information. For example, Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order and was PAT tested in July 2019.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. The computers were password protected with the screens positioned so that they were not visible from the public areas of the pharmacy. Cordless telephones were available to hold private conversations with people if needed.

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.