General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Grewal Chemists, 40 Chilwell Road, Beeston, NOTTINGHAM, Nottinghamshire, NG9 1EJ

Pharmacy reference: 1035614

Type of pharmacy: Community

Date of inspection: 15/08/2019

Pharmacy context

This is a community pharmacy in a suburban town on the outskirts of Nottingham. The pharmacy sells over-the-counter medicines and it dispenses NHS, private and veterinary prescriptions. It provides some of its services at a distance through its website. It offers a wide range of on-site services including remote access to consultations with a private doctor, and travel health services. And it is a registered Yellow Fever vaccination Centre (YFVC). The pharmacy also offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes and three local care homes.

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's working practices are safe and effective. It responds appropriately to people who raise concerns and provide feedback about its services. And its team have the necessary knowledge to recognise and report concerns to protect the welfare of vulnerable people. Pharmacy team members discuss mistakes they make during the dispensing process. And they use these discussions to reduce risk. The pharmacy has some systems in place to manage confidential information. And it acts quickly to manage any identified risks relating to confidentiality. The pharmacy generally keeps the records it must by law up to date. But some gaps in these records may result in inaccurate and incomplete audit trails. It has some procedures for supporting its team in delivering its services. But these procedures do not extend to all services provided. This could make it difficult for the pharmacy to demonstrate how all team members work to the same standards.

Inspector's evidence

The pharmacy was in a state of change as it had absorbed business from another of its branches which had closed in April 2019. This had led to changes in workflow, staffing and organisation within the pharmacy. All pharmacy team members from the closed branch had transferred across to the pharmacy. The pharmacy had been partially re-fitted to accommodate this change. And it now had two separate dispensaries, pharmacy team members primarily used the second dispensary for providing the care home services. Pharmacy team members demonstrated how they used space across both dispensaries effectively. They used separate space in each dispensary for labelling, assembly and checking medicines.

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The Superintendent pharmacist reviewed the SOPs at least every two years. SOPs included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and some services. But specific SOPs relating to the steps involved in supplying some medicines through the distance selling services were not in place. The pharmacy had previously held a wholesale dealers license. And as such had some SOPs in place did provide some further guidance on the safe supply of medicines at a distance. For example, managing the safe delivery of medicines. The manager led the online service. She demonstrated risk management processes for monitoring requests which included identifying repeat requests, some identification verification processes and searching professional registers to confirm the details of prescribers. But a discussion took place about how formalised procedures would help ensure all pharmacy team members could perform tasks associated with the service in a consistent and safe manner.

Pharmacy team members, including those who had recently moved to the pharmacy, had signed the SOPs. A new inductee who had worked at the pharmacy for two weeks had begun reading and signing SOPs relevant to her job role. She clearly explained what tasks could and could not be completed if the RP took absence from the premises. The team was observed completing dispensing tasks in accordance with SOPs throughout the inspection.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist at the time they occurred. But details of near-miss errors had not been recorded regularly for the last few

months. Pharmacy team members felt this was an effect of the two teams coming together and establishing new working process. Prior to the merge regular reporting of these mistakes was noted. Pharmacy team members explained how they always discussed their mistakes and acted to reduce potential risks following this discussion. For example, they had acted to separate some 'look alike and sound alike' (LASA) medicines in the dispensary drawers. The pharmacy had an incident reporting procedure in place. This involved notifying the superintendent pharmacist of incidents and reporting them through the National Reporting and Learning System (NRLS). But pharmacists did not always print and retain a copy of the report. There was evidence of reporting and actions taken to reduce risk documented on people's medication records. The RP explained he had completed a full annual patient safety review of near-miss errors and dispensing errors. And pharmacy team members could discuss the trends in mistakes the review had identified and could demonstrate risk reductions they had implemented. For example, the pharmacy team had considered the storage arrangements for gabapentin and pregabalin and had separated these medicines. A copy of the review was not available at the time of inspection.

The pharmacy had a complaints procedure in place. And it provided details of how people could comment on its services through its website. But it did not specifically publish its complaints process on its website. A comments book at the pharmacy counter invited feedback. And people engaged in leaving feedback in this way. The pharmacy also engaged people in feedback through its annual 'Community Pharmacy Patient Questionnaire'. A member of the team explained how she would manage and refer a concern on to the manager or a pharmacist. And pharmacy team members explained how they sought to resolve concerns. For example, by contacting prescribers when medicines were not available due to long-term manufacturing delays.

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice was updated at the beginning of the inspection to reflect the correct details of the RP on duty. Entries in the responsible pharmacist record generally complied with legal requirements, a few missed sign-out times was seen in the sample of the record examined. The pharmacy kept records for private prescriptions and emergency supplies within its electronic Prescription Only Medicine (POM) register. It marked copies of private prescriptions with details of the reference number generated in the register. This made it easier for the pharmacy team to chase queries. The pharmacy did not always enter the nature of the emergency when entering details of an emergency supply of medicine at the request of a patient. The pharmacy kept certificates of conformity for unlicensed medicines and completed audit trails on certificates in accordance with the requirements of the Medicine and Healthcare products Regulatory Agency (MHRA).

The sample of the CD register examined was compliant with legal requirements. The register was maintained with running balances. The pharmacy checked these balances when dispensing a CD. But the frequency of full-routine balance checks had lapsed. A discussion took place about the benefits of re-establishing regular full-balance checks of the register against physical stock. A physical balance check of Sevredol 10mg tablets complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. But the pharmacy had not entered several returns in the register at the point of receipt. The RP understood the rationale for entering returns into the register at the time of receipt and acted record the returns stored in the CD cabinet immediately.

The pharmacy displayed a privacy notice and had information governance procedures in place. Pharmacy team members had completed additional learning following the introduction of the General Data Protection Regulation (GDPR). The pharmacy had submitted its annual NHS information governance toolkit. It had secure arrangements in place to manage its confidential waste. It stored most personal identifiable information in staff only areas of the pharmacy. But some records, including

archived CD registers and travel health forms were held within folders in the consultation room. The documentation was not on open view. But people were left in the room alone to maintain their privacy when using the online doctor consultation service. This posed a small risk of the information within folders being accessed by unauthorised personnel. The team immediately began to manage this risk by removing the folders from the room and storing them in a secure location.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had completed some learning through reading procedures and engaging in conversations about safeguarding. Pharmacists had completed level two training on the subject. Pharmacy team members could explain how they would recognise and report a safeguarding concern. They explained how they would make further checks of concerns related to the use of their online services. The pharmacy team members discussed how they would share concerns relating to a deterioration in somebody's health and wellbeing with surgery teams. And they had access to reporting contact details for local safeguarding teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services and to manage its workload effectively. The pharmacy promotes openness and it has appropriate feedback mechanisms in place for its team. Pharmacy team members engage in regular conversations relating to risk management and safety. And they are supported through mandatory training for their roles. But the pharmacy does not adopt formal systems for recording outcomes of patient safety discussions or for the learning and development needs of its team members. This may mean there are some missed opportunities to share learning.

Inspector's evidence

On duty at the time of the inspection was the RP, a second pharmacist, the pharmacy manager (qualified dispenser), two other qualified dispensers and a new team member. In total the pharmacy employed four pharmacists including the Superintendent pharmacist, six dispensers, two medicine counter assistants, the new inductee and a delivery driver. The superintendent worked regular Saturdays at the pharmacy. Several team members were off at the time of inspection for various reasons. The new inductee had been employed to support the team over the summer period and there was some flexibility between working patterns of other members of staff.

Pharmacy team members completed the mandatory training required for their roles. The pharmacy displayed some certificates of qualifications belonging to its team members. Pharmacists undertaking the pharmacy's extended services had completed the necessary training to provide these services. And evidence of this training was available. Pharmacy team members did not receive regular access to continual training to support them develop in their roles. But explained training was made available for services when required. For example, some members of the team had engaged in healthy living training.

The superintendent pharmacist visited the pharmacy every Friday to speak with staff and address any learning needs or concerns. Focus in recent months had been on managing the merger of the two businesses. But the pharmacy did not record details of these discussions. Members of the team explained they could provide feedback to either the manager or a pharmacist, depending upon the issue being raised. The pharmacy had a whistle blowing policy in place and it advertised the details of this to its team members. Pharmacy team members could explain how they would escalate a concern if required. The inductee had worked in the pharmacy for approximately two weeks. She expressed that she felt well supported and could ask questions and go to any member of the team for support when required, the RP had full supervision of activity taking place at the medicine counter and could intervene to provide support when required. Pharmacy team members on duty were observed working together well and acknowledged that they were working through a period of change due to the two businesses merging.

The pharmacy team members were observed greeting people as they approached the medicine counter. Staff were friendly and engaged people in conversation about their health and wellbeing. A pharmacist explained how there was some encouragement to provide services. The pharmacy had annual targets in place for the Medicines Use review (MUR) and New Medicines Service (NMS). And

pharmacists took opportunities to engage with people when delivering other services such as flu vaccinations. For example, linking a MUR to a flu vaccination appointment. There was a strong emphasis on engaging with people through conversation and counselling. And both pharmacists explained how they made time to speak with people about their medicines, health and wellbeing their priority.

The pharmacy team generally shared information through informal but continual discussions. Pharmacy team members confirmed they were encouraged to participate in these discussions and could discuss changes to practices and stock layout made following conversations about patient safety. But the pharmacy didn't regularly record details these patient safety briefings to encourage reflection and share learning with other members of the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. The pharmacy team has access to facilities which allow people using the pharmacy to speak to a member of the team or have a consultation with a doctor in private.

Inspector's evidence

The pharmacy was clean and secure. Work benches in the dispensary were clear of unnecessary clutter. Pharmacy team members reported maintenance and IT issues to the Superintendent pharmacist. And the pharmacy used local tradespeople to manage any work required. The pharmacy had heating, and lighting was sufficient throughout the premises. It had air conditioning on the ground-floor and second-floor level. The first-floor level was cool, and fans were available to assist with ventilation on this floor. Antibacterial soap and paper towels were available close to designated hand washing sinks.

The public area was large and fitted with wide spaced aisles. This allowed people using wheelchairs and pushchairs to navigate around the pharmacy with ease. The pharmacy had a good size consultation room. This was uncluttered and clean. It was sign-posted and offered a suitable space for holding confidential conversations with people.

The dispensaries were across the back wall and a side wall, a stair case leading to the first floor separated the two. An area used for completing some administration tasks was also located between the two dispensaries. The dispensaries were an adequate size for the level of activity taking place. Further space for storing equipment and medicines was available on the first-floor and second-floor of the premises. The first-floor was somewhat cluttered with paperwork and equipment, some of which was due to the company closing its other nearby pharmacy. The clutter did not pose a health and safety risk and walk-ways and working areas were clear. Areas used to hold stock were clean and well organised.

The pharmacy’s website prominently displayed the pharmacy’s name and used both the mandatory MHRA medicine seller logo and GPhC voluntary internet pharmacy logo. The address of the pharmacy was prominent on the website. But a link providing the details of the superintendent pharmacist was not kept up to date and it as such was inactive. The superintendent pharmacist confirmed this issue would be rectified.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services and these are fully accessible to people. It obtains its medicines from reputable sources. And it stores and manages them appropriately to help make sure they are safe to use. It has some systems in place to provide assurance that its medicines are fit for purpose. The pharmacy works effectively to manage the risks associated with providing its services and its workload is generally well organised. It has systems in place to make sure people get the right medicines at the right time. But it doesn't always supply patient information leaflets when dispensing medicines in multi-compartmental compliance packs to people living in their own homes. This could mean that people do not have all the information they require to assist them managing their own medication.

Inspector's evidence

People accessed the pharmacy from street level through a push/pull door. Pharmacy team members explained how they would go to the door to assist people who may struggle to push the door open. The pharmacy advertised details of its opening times and services clearly. And pharmacy team members explained how they would signpost a person to another healthcare provider or pharmacy if they were not able to provide a service. The pharmacy had designated seating for people waiting for its services. And it had a small health promotion zone to one side of the medicine counter. Pharmacy team members engaged well with people visiting the pharmacy and knew many people by name.

A pharmacist demonstrated up-to-date patient group directions (PGDs) and procedures in place to support the travel health and vaccination services. The consultation room offered a professional environment for vaccinations. It had posters of world maps displayed which prompted conversations with people going on holiday. And a small range of clean toys were available for children attending for vaccinations. Two pharmacists provided the service. And it was accessible to people on a Saturday as well as during the week. The pharmacist reflected on beneficial outcomes from some of the pharmacy's other services. For example, referring people to their own General Practitioner (GP) to change their medicine when adverse side effects were noted during New Medicine Service (NMS) consultations.

The pharmacy was associated with two Care Quality Commission (CQC) registered prescribing services. Both used doctor prescribers and procedures for the services were up to date and available for inspection. One service was accessible in the pharmacy and provided people with access to a consultation with a doctor via a computer and webcam set up in the consultation room. The pharmacy provided diagnostic equipment such as a digital stethoscope, blood pressure machine and thermometer alongside the computer. The RP explained people were left to speak confidentially with the doctor during the consultation. But pharmacy team members made it clear they were available to support the person at any time during the consultation if required. Following the consultation, a private prescription was raised and sent to the pharmacy electronically if treatment was necessary. The second service was a remote prescribing service which could be accessed through the pharmacy's website. The pharmacy received few prescriptions through this service. The prescribing service had systems in place to check the identity of people it prescribed medicines to.

The pharmacy allowed people to order medicines for private prescriptions and veterinary medicines

through its website. People could add these to a basket and were given the price of the medicine. But it was clear that no medicine would be dispensed until an original valid prescription was sent to the pharmacy by post. The pharmacy kept details of queries and circumstances when they had to refuse the supply of a medicine. Identification verification checks were made through Sage Pay. And the pharmacy team members routinely checked the identity of prescribers and provided examples of how they had referred concerns about people trying to obtain medicines inappropriately to healthcare regulators and the police on occasion.

The pharmacy team members were aware of the risks associated with the supply of high-risk medicines. They demonstrated how prescriptions for medicines such as controlled drugs were clearly marked using stickers. Both pharmacists were observed personally handing out assembled medicines and taking the opportunity to counsel people in the safe use of their medicines. A pharmacist explained how checks of high-risk medicines including warfarin, methotrexate, valproate, non-steroidal anti-inflammatory drugs and diuretics would be through verbal counselling. But would not routinely be documented on people's medication records. This meant it could be difficult for the pharmacy to monitor the consistency of these checks. The pharmacy did have some valproate pregnancy prevention plan (PPP) warning cards available to issue to people in the high-risk target group.

The pharmacy used a planner to monitor workload associated with the supply of medicines in multi-compartmental compliance packs. Individual profile sheets were in place for each person on the service. And pharmacy team members documented changes to people's medication regimens on profile sheets. But they did not always record the date of the change. The pharmacy retained copies of hospital discharge summaries with profile records. A sample of assembled packs contained full dispensing audit trails. And the pharmacy provided clear descriptions of the medicines inside the packs to help people identify them. But it did not regularly supply patient information leaflets when dispensing these packs. A discussion took place about the requirement to supply these leaflets.

The pharmacy provided medicines to care homes in two different style multi-compartmental compliance packs. One system held multiple medicines inside each compartment over a seven-day period. The other used separate pack inserts for each medicine over a 28-day period. It arranged these inserts on a colour coded rack system by time of day. Care homes ordered their own prescriptions and notified the pharmacy of what was ordered through annotation on medication administration record (MAR) sheet. This allowed the pharmacy to chase queries and missing prescriptions. The pharmacy recorded any outstanding queries and sent these back to the homes. The pharmacy supplied MAR sheets for all medicines it dispensed to the homes. These included body maps and warfarin charts. And it routinely supplied patient information leaflets to the homes when dispensing a medicine. There was a full dispensing audit trail in place for the 28-day packs supplied and for interim items. But only the pharmacist signed the seven-day packs. This meant it could be more difficult for the pharmacy to identify who had been involved in the dispensing process and provide feedback to them should a query arise. The pharmacy received original prescriptions ahead of dispensing acute items to the homes.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained delivery audit trails for the prescription delivery service. Deliveries sent through the post were sent via Royal Mail Signed For delivery. The manager demonstrated how cold chain medicines were posted in specialist packaging.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy

team members demonstrated an awareness of the aims of the Falsified Medicines Directive (FMD). The pharmacy had recently installed a new clinical software programme to assist with becoming FMD compliant. It was registered with SecurMed and had scanners waiting to be installed. The pharmacy received drug alerts through email. The pharmacy team printed alerts and ran a search on the clinical software programme to identify any supplies of the affected medicines which may have been made. There was evidence of the pharmacy contacting people about drug alerts when necessary. All alerts were kept for reference purposes and held with detailed accounts of the checks made.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. On-line sales of P medicines were reviewed by the manager and brought to the attention of a pharmacist. These formed a very minor proportion of overall sales as most sales were for appliances, vitamins and toiletries. The pharmacy telephoned people ahead of supply P medicines to go through safety questions and counselling with them. The manager provided several examples of the pharmacy declining inappropriate requests and it did not sell high-risk P medicines such as codeine-based painkillers via its website.

The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. The pharmacy team followed a date checking rota to help manage stock. It identified short dated medicines and annotated details of opening dates on bottles of liquid medicines. One out-of-date medicine was found during random checks of dispensary stock,. It had been highlighted by the team as short dated but had not been removed from stock prior to its expiry date. It was immediately removed and brought to the direct attention of a team member. The medicine was highlighted as short-dated to prompt additional checks during the dispensing process. Pharmacy team members were also observed checking expiry dates of medicines during the dispensing process. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. CDs were easy to find and stored in an orderly manner. There was designated space for storing patient returns, out-of-date CDs and assembled CDs. Pharmacy team members could explain the validity requirements of a CD prescription and discussed additional safety checks of these prescriptions applied during the dispensing process. The pharmacy had four operational fridges which provided ample amounts of storage room for cold chain medicines. A fifth fridge was available in the event a fridge became non-operational. Fridges were clean and stock inside was stored in an organised manner. Temperature records confirmed the fridges were operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to all the equipment it needs for providing its services. It uses this equipment in a way which protects people's confidentiality. The pharmacy has some monitoring systems in place for its equipment and it replaces equipment at regular intervals.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. The internet provided the team with further information and a pharmacist demonstrated how this was used to access supportive documentation for the travel health service. Computers were password protected and computer monitors faced into the dispensary. Computers in the consultation room required unlocking prior to use. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines to the side of the dispensary. This protected people's private information against unauthorised view. The pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This meant they could move out of ear-shot of the public area when having confidential conversations over the phone.

Clean, crown stamped measuring cylinders were in place. The pharmacy used separate cylinders for measuring methadone. The pharmacy had clean counting equipment for tablets and capsules. Pharmacy team members assembled medicines into single-use multi-compartmental compliance packs. The pharmacy team visually monitored its equipment and replaced equipment periodically. Electrical wires and plugs were visibly free from wear and tear. But the pharmacy had not commissioned any safety checks of its electrical equipment for some years.

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.