General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Duggal Chemist Limited, Unit 8, Mostyn Buildings, Lower Church Lane, TIPTON, West Midlands, DY4 7PE

Pharmacy reference: 1038459

Type of pharmacy: Community

Date of inspection: 28/05/2024

Pharmacy context

This community pharmacy is located in a small parade of shops in a residential part of Tipton. It dispenses NHS prescriptions and sells medicines over the counter. The pharmacy provides additional services including a minor ailments scheme and seasonal flu vaccinations. A substance misuse service is also available. The pharmacy supplies some medicines in multi-compartment compliance aid packs, to help make sure people take their medicines at the right time. Medicines are also delivered to people's homes.

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 review its standard operating procedures (SOPs) regularly. The SOPs contained outdated information and do not always reflect the current working practices. This means its team members may not be working in line with the written instructions that are in place to deliver services in a safe an effective manner.
		1.2	Standard not met	The pharmacy does not keep a record of the mistakes that occur during the dispensing process (near misses). And it does not proactively review these mistakes which means it may not identify common mistakes and trends. Its team members may miss out on learning opportunities following a mistake.
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 not all met**

Summary findings

The pharmacy has written procedures which covers the services that it provides. But they are outdated and do not reflect the current working practices. This means its team members may not understand the correct processes to follow to help them work in a safe and effective manner. Mistakes that occur during the dispensing process are not recorded or reviewed, this means team members may miss out on opportunities to learn from them and improve the safety of the service they offer. The pharmacy largely keeps the records it needs to by law. And its team members know how to protect people's private information.

Inspector's evidence

The pharmacy had a range of standard operating procedures available, but they were last reviewed in 2017 despite this being highlighted in a previous inspection six months ago. The SOPs referenced outdated information and referred to organisations such as Primary Care Trusts, which no longer exist. And some of the key SOPs did not reflect the current working practices. For example, the procedure for dispensing prescriptions referred to paper prescriptions instead of electronic ones. A SOP for multi-compartment compliance packs detailed the use of dispensing labels instead of backing sheets and the delivery SOP required deliver drivers to obtain signatures when delivering controlled drugs (CDs) which was not being done. This meant that team members may not understand or follow the procedures that were in place. A dispenser, who was also one of the directors of the pharmacy, explained that team members has read and signed the SOPs when they were first employed, but there was no record of this training being completed.

A written process for the recording of mistakes identified during the dispensing process (near misses) was available. The director explained that the responsible pharmacist (RP) asked the dispenser involved to identify the mistake and correct it. But no records of any near misses had been made and mistakes were not reviewed to help identify any common errors to allow the team to take the appropriate actions to reduce the risk of them occurring again. This also meant team members missed out on opportunities to learn from their mistakes which would support their development.

There was a complaint procedure, and any concerns were usually referred to the pharmacist or one of the directors of the company which owned the pharmacy. People using the pharmacy's services were able to provide feedback verbally. Feedback surveys had previously been completed, but none had been done in recent years.

The incorrect RP notice was initially displayed, but this was rectified by the pharmacist when highlighted. The RP log, private prescription record and records of the supply of unlicensed medicines were generally in order. Controlled drug (CD) registers were completed as per the requirements and a running balance was maintained, but balance checks were completed infrequently. The physical stock of five CDs were checked against the recorded running balance and one was found to be incorrect. The RP investigated the discrepancy and identified a missing entry when a person had been supplied one of the medicines. CDs returned to the pharmacy were recorded in a book which was signed when they were destroyed. The pharmacy had professional indemnity insurance and a certificate was available. Team members were able to explain the tasks that could and could not be completed in the absence of an RP.

An information governance policy was available, and members of the team signed confidentiality agreements when they first started working in the pharmacy. When questioned, a dispenser explained that they would use the consultation room to help maintain privacy and how they separated confidential waste which was then shredded on site or disposed of using an appropriate waste carrier.

The pharmacist had completed safeguarding training and the contact details of local safeguarding agencies were accessible. A team member explained the types of concerning behaviours that might be identified. Any concerns were escalated to the pharmacist and a previous concern had been raised through appropriate channels.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. And it provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback. There is no structured ongoing training so the pharmacy may not always be able to demonstrate how its team members keep their knowledge up to date.

Inspector's evidence

The pharmacy team consisted of two full time dispensing assistants and a regular locum pharmacist who was the RP. Some members of the team were absent, this included three part time dispensers, two medicines counter assistants and one part time delivery driver. One of the dispensing assistants was enrolled on to the pharmacy technician course with a local college and another dispensing assistant was one of the directors of the pharmacy. The pharmacy team members were seen working well together and they supported each other to manage the workload effectively.

A dispenser was able to explain the questions they would ask when selling over-the-counter medicines and was aware of the medicines that may be misused. They would refer any sales of pharmacy medicines (P-Meds) to the pharmacist to help make sure the medicine was appropriate for the person requesting it. And they would also refer any repeated purchases to avoid medicines being abused.

The pharmacy did not provide any ongoing structured learning for its team members to develop their skills and knowledge. The only training provided was for those on an accredited training course. Members of the team received an appraisal every two years and they were able to discuss any desires to progress or undertake additional training. It was also an opportunity to discuss their performance and raise any concerns they may have. Team meetings took place once a quarter and provided the pharmacy owner with an opportunity to talk about business and operational related topics as well as any concerns and to receive feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally suitable for the services that it provides. Some areas are cluttered and untidy which detracts from a professional appearance. There is a consultation room for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was large enough for the volume of work undertaken. It was generally clean but untidy in some areas. There were some boxes stored on the floor due to the lack of bench space and shelving space, but this did not pose a trip hazard. The pharmacy was well-lit, and the temperature was maintained to a suitable level. Some of the workbenches were cluttered which may increase the risk of mistakes happening during the dispensing process but the pharmacist checking bench was clean and tidy. A clean sink was available and suitable for preparing medicines that required mixing before being supplied to people.

A storage room was available at the back of the premises which was secured from unauthorised access. The storage room was untidy. A clean consultation room was available and suitable for people to have a private conversation if needed. However, it was untidy and was being used to store paperwork and obsolete medicines, which made it look unprofessional. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides the services it offers in an effective manner. The pharmacy gets its medicines and devices from appropriate sources. Its team members carry out sufficient checks to make sure they are safe to supply to people, but they do not record the checks, which means some medicine stock may be overlooked. Members of the team are not always aware when higher risk medicines are being supplied, so they may not always provide additional advice to people to help make sure they are still safe to use.

Inspector's evidence

There was a small step at the entrance of the pharmacy which led into a small retail area. Members of the team assisted those with mobility issues and a portable ramp was available. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they required additional health related information.

The pharmacy provided some NHS services including the New Medicine Service and a minor ailments scheme. Volumes of these services were low. A seasonal flu vaccination service was provided during the winter months, but uptake was generally low. A supervised consumption of higher risk medicines was in operation and people were accompanied to the consultation room for privacy when using the service.

NHS prescriptions were received electronically, and dispensing baskets were used to keep individual prescriptions separate to avoid medicines being mixed up during the dispensing process. Dispensed medicines awaiting collection were bagged and stored securely away from unauthorised access. The pharmacist attached stickers to the bags to highlight when controlled drugs or fridge lines needed to be added. This also acted as a prompt for team members to check the validity of CD prescriptions before being supplied to people. A sticker was also attached to the top of a prescription to highlight when counselling by the pharmacist was needed. A dispenser explained how they always asked people to confirm their names and addresses before medicines were handed out, to make sure they were supplied to the correct person. Some people had their medicines delivered to their homes and a record of the successful deliveries was maintained but there was no indication of what date or time the delivery was made. The delivery driver did not request a signature when a CD was delivered which went against the written procedures. This meant that the pharmacy may not be able to appropriately respond to a query following a delivery.

The pharmacy had a medicine collection point at the front of the pharmacy, which allowed people to collect their assembled prescriptions when the pharmacy was closed. Suitable prescriptions, which did not include CDs, fridge items and glass bottles were stored within the collection unit. People were notified by text message that their medication was ready to collect and received a PIN to access their prescription. Prescriptions were removed from the collection point, if they were not collected within seven days.

The RP was aware of the risks associated with the use of valproate during pregnancy and an audit of valproate patients had been carried out. The pharmacy did not currently have any patients who met the risk criteria, but the pharmacist knew that such patients should be counselled. The pharmacy team knew that valproate should always be supplied in original packs and knew how to attach dispensing

labels to avoid covering important information.

The pharmacy supplied medicines in multi-compartment compliance packs to people that required support with taking their medicines correctly. A dispenser explained that they contacted each person before their medicines were due to check what they needed before ordering the prescription with the GP. Record sheets were kept for all the patients, showing their current medication and dosage times. This information was checked against repeat prescriptions and any discrepancies would be checked with the surgery. Any changes to medicines were also recorded on the person's patient medication record (PMR). The compliance packs were labelled with descriptions, so people could identify the individual medicines. But patient information leaflets were not routinely supplied so people may not be able to access additional information if needed.

The pharmacy obtained its medicines from licensed wholesalers and unlicensed specials were ordered from a specials manufacturer. Stock medicines were stored tidily. The expiry dates of medicine stock had been checked two weeks ago, but there was no record kept of the checks. This meant that some stock may be overlooked. Controlled drugs were appropriately stored in a locked cabinet. There were two medicines fridges available which were clean, tidy, and equipped with thermometers. The maximum and minimum temperatures were recorded daily but it did not reflect the actual temperatures. The maximum temperature of the fridges when checked were 14.7 and 13.8 degrees Celsius. However, the actual temperature of both fridges was seen to be in the recommended range of 2-8 degrees Celsius. This was highlighted to the RP who reset the thermometers and provided an assurance that it would be investigated and that they would periodically check the temperature to make sure it fell back into range. Waste medicines were disposed of in dedicated bins that were collected periodically by a specialist waste contractor. Drug alerts and recalls were received electronically, and records were kept but they didn't show what action, if any, had been taken. So, it may make it harder to respond to a query following an alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting triangles. Members of the team had access to electronic resources such as the British National Formulary (BNF) and the electronic medicines compendium. This meant the pharmacy team could refer to the most recent information on medicines.

Electrical equipment looked to be in good working order. Two computer terminals were available for team members to use, and the screens were positioned in a way so that any confidential information could not be seen by people waiting in the pharmacy. Access to people's electronic data on the pharmacy's computers were password protected.

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.