General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sidhu's Pharmacy, 369 High Street, WEST BROMWICH, West Midlands, B70 9QL

Pharmacy reference: 1038539

Type of pharmacy: Community

Date of inspection: 30/07/2024

Pharmacy context

This community pharmacy is located on the main high street in West Bromwich town centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses prescriptions and sells medicines over the counter. It offers several additional services including the NHS Pharmacy First service, blood pressure testing and seasonal flu vaccinations. The pharmacy also supplies some medicines in multi-compartment compliance packs to help make sure people take their medicines at the right time.

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	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 team follows written procedures, and this helps to provide services safely and effectively. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They record things that go wrong and discuss them to help identify learning. But they do not formally review the records to look for common or underlying trends. So there may be a risk of similar mistakes happening again.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) covering operational tasks and activities in the pharmacy. Members of the team had signed training sheets to indicate they had read and understood the SOPs.

Near miss incidents were routinely recorded in a near miss log. The pharmacist explained they occassionaly reviewed the record on an ad hoc basis to look for repeated mistakes. They discussed the review as part of team meetings. But the review and any actions taken were not recorded to help show learning from underlying trends. So the pharmacy may not be able to explain the learning points they had identified. Posters which identified common 'look alike, sound alike' medicines were displayed in the dispensary. To help prevent a picking error, the different strengths of furosemide 20mg and 40mg tablets were moved away from one another. The pharmacist explained the incident reporting procedure and explained any issues that could not be resolved in the pharmacy would be escalated to the pharmacy director.

The SOPs were colour coded to define the roles and responsibilities for members of the team. When questioned, a dispenser was able to describe what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a responsible pharmacist (RP). The correct RP notice was on display. People using pharmacy services could provide feedback verbally. Concerns were generally referred to the manager in the first instance. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drug (CD) registers were accessed on an electronic platform and running balances were recorded. The pharmacist confirmed they had been routinely checking the CD balances against the current stock, but the electronic platform had not been recording these checks. The pharmacist identified they had been using the software incorrectly and understood how to record these checks going forward. Four random balances were checked, and all were found to be accurate. A separate register was used to record patient returned CD medicines.

Pharmacy team members had an understanding of confidentiality and had completed data protection e-learning. No patient identifiable data was visible from the medicine counter and a policy was displayed explaining how the pharmacy used and managed data people's personal. Confidential waste was separated and shredded. Several members of the pharmacy team had completed safeguarding training and the contact details of local safeguarding agencies were accessible. There was a chaperone policy displayed at the entrance to the consultation room. When questioned, a dispenser said they would report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough members of the team to manage the pharmacy's workload and they are appropriately trained, or undergo training, for the jobs they do. Members of the pharmacy team complete training to help them develop their knowledge.

Inspector's evidence

The pharmacy team included a pharmacist, a trainee pharmacy technician, five dispensers, two medicine counter assistants, and three drivers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be well managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

The pharmacy provided the team with e-learning training packages which appeared relevant to the services provided. Members of the pharmacy had recently completed a training pack about safeguarding. Training records were kept showing what training had been completed.

A medicine counter assistant gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. Members of the team were seen working well together and assisting one another with any queries they had. A dispenser felt a good level of support from the pharmacist and manager and able to ask for further help if they needed it. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or superintendent pharmacist (SI). There were no targets in place for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained and provides an appropriate space for the delivery of healthcare services. It has a consultation room, so people are able to have a conversation with team members in private. But it may not be accessed easily by people with mobility issues.

Inspector's evidence

The pharmacy was in a good state of repair. There was a retail area which generally stocked a range of goods suitable for a healthcare-based business. But there were some carbonated drinks for sale which may not be in keeping with promoting healthy living. Pharmacy medicines were secured behind the medicine counter. The dispensary was suitably sized for the volume of dispensing and there were separate areas for dispensing and checking. An area off the main dispensary was used for the assembly of multi-compartment compliance packs. There was a small room to the front of the premises, with a separate entrance which was being let out to an independent business.

The pharmacy had a consultation room which was well maintained and had a desk and seating to support private and confidential discussions. The room was accessed via some steps, so it may not be accessible to people with mobility issues. The team explained that a portable ramp was used to the side of the premises to access the room, when necessary. But this substitute entrance led through to the compliance pack dispensing area and may pose a confidentiality risk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible. And it manages and provides them effectively. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy was accessible from the main high street and there was an automatic door to assist with entry. Most pharmacy team members were bilingual and communicated with patients in several different languages when providing counselling. The pharmacy's services were advertised throughout the retail area and additional health promotion materials were on display.

Prescriptions were dispensed into baskets to help keep them separate and reduce the risk of medicines being mixed up. Baskets were colour coded to help prioritise the workload. An audit trail for dispensing was kept by team members signing 'dispensed-by' and 'checked-by' boxes on dispensing labels. Stickers were used to identify prescriptions for CDs to help make sure supplies were made within the valid expiry date. And the pharmacist provided ad hoc counselling to people about their medicines, including those taking higher-risk medicines (such as warfarin, methotrexate, and lithium). But this was inconsistent, and details of the counselling advice was not recorded. So there may be gaps in the care provided. Members of the team were aware of the risks associated with the use of valproate-containing medicines in pregnancy, and the need to supply full packs. Educational material was provided when medicines were supplied. And the pharmacist had spoken to those at risk to make sure they were aware of the pregnancy prevention programme. But this was not recorded which would be useful in the event of a query or a concern.

The pharmacy ordered repeat prescriptions via NHS Mail and kept a record of requests through the patient medication record (PMR) system. Multi-compartment compliance packs were organised using a four-week schedule. A master record of medicines that each person was supplied with was maintained and updated with the details of any changes. Packs which were being dispensed had patient details on the front and descriptions were present to enable individual medicines to be identified. But patient information leaflets were not routinely supplied. So people may not always have up to date information about their medicines.

The delivery service was organised using an electronic app. The system contained satellite navigation which planned driver routes and QR codes were used to record successful deliveries. Failed medicine deliveries were returned to the pharmacy.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The expiry dates of medicines were checked every two to three months. A date checking record was kept as a record of what had been checked. Short-dated stock was highlighted using a sticker and removed three months before the expiry date. Liquid medication had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet. There were two clean medicines fridges, each equipped with a thermometer. The minimum and maximum

temperatures were being recorded daily and records showed they had remained in the required range for the last month. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received through an electronic platform. When the pharmacist read and actioned the alert, the platform recorded details of when and how this had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. Team members use the equipment in a way that protects people’s privacy.

Inspector's evidence

The pharmacy had access to reference textbooks including the British National Formulary (BNF) and general internet access was also available. There was a range of approved measure for measuring liquids. A separate measure was marked for use with CDs. Counting triangles for tablets were also available and equipment appeared to be suitably maintained.

Electrical equipment was in working order. Computer screens were password protected and screens faced away from public view. Cordless phones were available to enable conversations to take place in private.

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.