General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Z. A. Akram, 22 High Street, Wombwell, BARNSLEY, South Yorkshire, S73 0AA

Pharmacy reference: 1039093

Type of pharmacy: Community

Date of inspection: 17/04/2019

Pharmacy context

This is a community pharmacy on a shopping parade with several other local shops. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy offers advice on the management of minor illnesses and long-term conditions. It also supplies medicines in multi-compartmental compliance packs to people living in their own 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's standard operating procedures (SOPs) are not reviewed when they are supposed to. And so, they may not reflect current practice. The team members do not use baskets to segregate different prescriptions and medicines. And this has led to an error.
2. Staff	Standards not all met	2.2	Standard not met	There is evidence that some team members carry out activities for which they are not appropriately qualified or trained.
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 check and record the fridge temperature ranges for all the fridges it uses to store medicines. So, it can’t be certain its medicines are always fit for purpose.
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 available which the team refer to. But they are not regularly reviewed. And so, they may not reflect current practice. The pharmacy has not managed the various risks associated with its dispensing process. And, those risks have led to errors. The pharmacy has procedures in place for people to provide feedback on how they provide services. And it generally keeps people's private information safe. The pharmacy has basic material readily available to its team members, to help them protect the welfare of vulnerable people. The pharmacy doesn't have a structured system in place to help the team to record mistakes and to learn from them. The pharmacy keeps most records as it should by law.

Inspector's evidence

The dispensary had a manageable workflow with separate, areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. But they were not used. So, there was a risk that medicines for different people may be mixed up. There was a separate bench used for a team member to make up the multi-compartmental compliance packs.

The pharmacy had a set of standard operating procedures (SOPs). These procedures were set to be reviewed every two years. This ensured that they were still relevant and up to date. But the last review was completed in January 2016. Each team member had read all the SOPs that were relevant to their role.

A process was in place to report and record errors that were made during the dispensing process. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. A small book was used to record details of the errors. But the team did not record every error made. No errors had been recorded in February and March 2019. The team sometimes forgot to record the details of the errors as they were often too busy. And they had recently noticed that they were making several picking errors involving different strengths of atenolol. The team separated the 5mg and 10mg strengths to reduce the risk of the errors happening again. And the team reported that they had not made any such errors since.

The team members had a procedure in place to report and record details of any errors that had inadvertently been supplied to people. The procedure involved recording details of the incident into a book. The pharmacy had recently supplied a person with another person's medicine in error. The team members identified that the error happened because the erroneous medicine was stored too closely to the person's prescription. And the medicine was not properly segregated because the team members did not use the baskets that they had available to them. This was not in line with the pharmacy's SOPs.

The pharmacy had a procedure in place to handle and report complaints from people who used the pharmacy. The procedure was not displayed for people to see. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The pharmacy did not display the results of the latest questionnaire.

The pharmacy had up to date professional indemnity insurance. The responsible pharmacist notice

displayed the correct details of the responsible pharmacist on duty. The responsible pharmacists did not always record the times that their duties ended. This is not in line with requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained, but there was limited evidence of regular auditing. A random CD item were balance checked and verified with the running balance in the register (Methylphenidate 20mg X 36). A CD destruction register for patient returned medicines had not been used since 2012.

Records of private prescription supplies were appropriately maintained. A sample of records for the receipt and supply of unlicensed products looked at found that they met requirements. The team held most records containing personal identifiable information in staff only areas of the pharmacy. But some prescriptions were seen piled on the desk in the consultation room. And, so there was a risk that people who used the room could see other people's information. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was then destroyed using a shredder.

The pharmacy stored medicines that were waiting to be collected, in a way that prevented people's confidential information being seen by members of the public. And computer screens were adequately positioned to ensure confidential information wasn't on view to the public. The computers were password protected.

The team had access to a flow chart which described how they could manage and report a concern about the welfare of vulnerable people. A contact number for the Barnsley safeguarding team was available. The team had not completed any training.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy generally employs people with the right skills to undertake the tasks within their role. But some team members dispense medicines, when they are not qualified to do so. The pharmacy supports team members to discuss their performance and identify learning needs. And they can generally raise professional concerns where necessary.

Inspector's evidence

The pharmacy was staffed by the regular pharmacist who worked full-time, two full-time pharmacy assistants, a part-time pharmacy assistant, a part-time counter assistant and a delivery driver. The team members who were not present included a part-time accuracy checking technician and a part-time counter assistant. The accuracy checking technician was also the pharmacy supervisor.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence. The counter assistant was observed completing some dispensing tasks These tasks included labelling and picking medicines from shelves. This is not in line with requirements.

The team members said that they had time during the working day to organise their continuing professional development. And to learn about new over-the-counter products or the uses of prescription only medicines. Several team members felt that they were well supported by the pharmacist. And they could ask the pharmacist questions openly about various healthcare conditions as they worked so closely together.

The team members attended a team meeting which was held every one to two months. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. The team had recently discussed making sure that at least two pharmacy assistants were working alongside the pharmacist at any one time. This was in response to an increased dispensing workload.

The pharmacy team members received a formal performance appraisal every year. The appraisal was in the form of a one-to-one conversation with either the regular pharmacist or the accuracy checking technician. They were given the opportunity to discuss various aspects of their performance, including what they had done well, what could be improved, and any learning needs they had identified.

The team described how they would raise professional concerns. Their explanations gave a clear understanding of how they would protect against professional risk and who they would raise their concerns with starting with their pharmacist and then escalating to the superintendent pharmacist. A whistleblowing policy was not in place. So, the team members may find it difficult to raise a concern anonymously. The team were not set any performance related targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and is adequately maintained. It has a consultation room which allows people to have private conversations. The team dispense multi-compartmental compliance packs in an area of the pharmacy which is poorly lit. This increases the risk of errors being made.

Inspector's evidence

The pharmacy appeared professional. And was generally clean, hygienic and well maintained. Floor spaces were mostly clear, with no trip hazards evident. There was clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The first floor contained an office and a spacious stock room.

Temperature was comfortable throughout inspection. The lighting was poor above the bench which was used to dispense the multi-compartment compliance packs.

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

Summary findings

The pharmacy provides a range of services that can help people to meet their health needs. But it doesn't have robust processes in place to ensure that the medicines they supply to people are fit for purpose. The pharmacy team identifies some risks associated with its services such as dispensing. And it generally manages the risk. But it doesn't supply leaflets to people taking some high-risk medicines. So, they may not receive all the information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy could be accessed from the street which led to an automatic door. The access was level. This allowed easy access for people who used wheelchairs or other mobility aids. The services on offer were advertised in the front window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. Several healthcare related posters were displayed in the retail area. These included promoting self-care and the NHS 111 scheme.

Written notes were used on prescription bags to alert the team to issues on hand out. For example, interactions or to remind the pharmacist to provide a person with additional advice. An audit trail was not in place for dispensed medication. Typically, pharmacies use dispensed by and checked by signatures on labels. A procedure was not in place to highlight dispensed controlled drugs, that did not require safe custody. And so, there was a risk that the medicine could be supplied to people after the prescription had expired. The team only dispensed fridge and CD items when the person presented in the pharmacy, or just before the delivery was due to leave the premises.

The team occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team did not have access to any literature about the programme that they could provide to people.

People could request multi-compartmental compliance packs. The team were responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases/decreases, on the master sheets. The details of the prescriber authorising the change were not recorded. The team advised that they supplied the packs with backing sheets which contained dispensing labels. And they provided people with descriptions of the medicines contained in the packs. And so, people could visually identify the medicines if they needed to do so. The team supplied patient information leaflets to people each month.

An audit trail for the delivery of medicines from the pharmacy to people was in place. A note was posted to people when a delivery could not be completed, to advise them to contact the pharmacy.

There were occasions where the team could only provide people with a part-supply of their medicines due to stock availability. But people were not provided with a written record of this.

Medicines that can only be sold in a pharmacy, and under the supervision of a pharmacist, were stored behind the retail counter. This prevented people from self-selecting these medicines.

The team checked the expiry dates of stock every three months. And the team kept a record of the activity. No out of date medicines were found following a random check of the dispensary stock. The team used alert stickers to highlight any stock that was expiring in the next six months. The date of opening was not recorded on liquid medication that had a short-shelf life once opened. And so, the pharmacy could not be certain that the medicine was still fit for purpose once it had been opened.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). New, updated software and scanners were available to assist the team to comply with the directive. But the team had not received any training on how to do so.

A controlled drug cabinet was in place and secure. The pharmacy used three fridges. And all of them contained medicines that required cold storage. One fridge also contained some food items, such as milk. The temperatures for one fridge were checked and recorded each day. But the team did not check or record the temperatures for the other two fridges.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned immediately. The team did not keep a record of the action taken following the recall. So, it couldn’t evidence that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people's confidentiality.

Inspector's evidence

References sources were available. And the team had access to the internet as an additional resource. The resources included a British National Formulary (BNF) and the BNF for Children. But they were not current issues. The pharmacy used a range of CE quality marked measuring cylinders.

The team used separate cylinders for dispensing methadone. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs.

The computers were password protected and access to peoples' records were restricted by the NHS smart card system. Cordless phones assisted in undertaking confidential conversations.

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.