General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Birk and Nagra Chemists, Unit 5 Cressida Close, Heathcote, WARWICK, Warwickshire, CV34 6DZ

Pharmacy reference: 1085466

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

This is a community pharmacy set in a row of shops in a residential area of Warwick. The pharmacy is near a GP surgery and a large housing development. The pharmacy is open six days a week. It sells a range of over-the-counter medicines and dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance aids to approximately 50 people living in their own homes. The pharmacy's dispensing business had increased by about 50% over the last year due to a new housing development in the area.

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	1.2	Standard not met	The pharmacy lacks systems to review and manage the safety and quality of services it provides.
		1.7	Standard not met	The pharmacy does not follow its information governance procedures to manage people's personal information safely.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy's staffing profile does not provide assurances that services are delivered effectively. It does not have sufficient contingency arrangements to manage workload adequately.
		2.2	Standard not met	Not all members of the pharmacy team have the appropriate qualifications for their role and the tasks they carry out.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is untidy and cluttered. It does not have sufficient space to undertake services safely and effectively.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy is unable to provide assurances that medicines requiring refrigeration are stored at appropriate temperatures all the time. And there is no evidence to show that remedial action is taken when temperatures fall outside the required range. And out of date medicines are present in stock and the pharmacy is unable to demonstrate that there are effective arrangements in place for removal of the expired medicines in stock.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy has procedures for the services it provides. But it has not reviewed these recently. And the procedures do not set out clearly the roles and responsibilities of its staff. So, staff members may not always be undertaking tasks as intended. The pharmacy team members aim to minimise risks associated with providing pharmacy services. But, they don't routinely record and review mistakes that are picked up during the dispensing process. So, they may be missing opportunities to improve the safety and quality of the services they provide. The pharmacy keeps the records that it must do by law. But it doesn't make sure they always contain all the information they need to. So, some records may not always be reliable if there is a query. The pharmacy has safeguarding procedures and its team members understand how they can help to protect vulnerable people. The pharmacy does not have information governance procedures in place. It does not always keep or dispose of people's private information securely. And its team members have not received appropriate training and have not signed the confidentiality agreement.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided. But none of them had been reviewed in accordance with the review dates stipulated on them. For example, the responsible pharmacist (RP) SOPs were due to be reviewed on 31 March 2016, the SOPs for the safe usage of higher-risk medicines were due to be reviewed on 1 July 2014, SOPs for the safe management of controlled drugs were due to be reviewed on 31 March 2018. The pharmacy's business continuity plan had not been reviewed since March 2017 and had not taken into account the pharmacy's changing workload.

The pharmacy had an SOP for dispensing errors and near misses. But the pharmacy team members did not routinely review or fully document their mistakes to help prevent them happening again. Records of dispensing errors were kept either on a paper format or electronically. There were records of dispensing errors recorded in 2016 and 2017 and one record documented in 2019. Records of near misses did not include enough detail of contributory points or learning points to allow any meaningful analysis. There was no evidence to show that the pharmacy team members had taken any actions to mitigate future risks a result of mistakes.

A responsible pharmacist (RP) notice was on display. Members of the pharmacy team understood their roles and responsibilities, but these were not described within the SOPs. A recently recruited dispenser understood the tasks she could or could not undertake in the absence of a RP.

The pharmacy had a complaints procedure and information for people about this was included in the pharmacy's practice leaflet. Results of the survey conducted in 2017 to 2018 were on display and were generally positive. But the information displayed did not include any actions the pharmacy were taking to address areas for improvement. The associated document for the survey results conducted in 2018 to 2019 had not yet been attached on the NHS website.

The pharmacy's records for RP, private prescriptions and unlicensed specials were maintained in line with requirements. Patient-returned controlled drugs were recorded in a separate register. The headings on some of pages of the controlled drug (CD) register were incomplete. The balance of stock of an item checked at random matched the recorded balance in the register.

The pharmacy's electronic records for emergency supply made at the request of patients were adequately maintained. But some records did not include the nature of the emergency. An Information Governance policy was in place. There were some records available to show that members of the pharmacy team had signed the confidentiality agreement. But a member of staff recently recruited had not signed a confidentiality agreement.

The pharmacy's shredder was not working and it had not been replaced. People's confidential waste was left to soak in a large bowl of water for few days till the paper disintegrated, it was then disposed of with the general pharmacy waste. This did not provide assurances that people's private information was illegible.

The pharmacy had the General Data Protection Regulation (GDPR) training manual available, but there was no evidence to confirm that staff had completed this training. The pharmacy's consultation room was not kept locked and there were prescriptions, people's confidential information and medical devices not safeguarded against unauthorised access. Some patient-returned multi-compartment compliance aids had been discarded in the designated bin for storing waste medicines with dispensing labels and patient information still attached and intact. Prescriptions awaiting collection were stored haphazardly. But people's personal details on them were not visible to the public.

A safeguarding policy was in place and the pharmacist had completed level 2 safeguarding training. The pharmacy had indemnity insurance arrangements in place.

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

Summary findings

Not all members of the pharmacy team have the appropriate skills and qualifications for their roles. And the pharmacy's staffing arrangements do not reflect the current increase in the workload. Its team members are not coping with their current dispensing workload and have little or no time for other routine tasks such as training, some record-keeping tasks or stock-checking tasks.

Inspector's evidence

The pharmacy opened for 46.5 hours a week and dispensed between 6,000 to 6,300 prescription items in a typical month. The pharmacy's dispensing business had increased by about 50% over the last year due to a new housing development in the area. The pharmacy team consisted of a full-time pharmacist and a full-time counter assistant. A full-time dispenser had been recently recruited. The pharmacy was open for four hours on Saturday during which time they dispensed between 100 to 130 prescription items. And the staffing consisted of an untrained counter assistant and a pharmacist.

A regular locum pharmacist, a medicine counter assistant and a dispenser were on duty during the inspection. The locum pharmacist covered 2.5 days per week. Although the team members were working well together and supportive of each other, they were struggling to cope with the workload. There were queues of people waiting to be served. The workflow in the pharmacy was chaotic. The team members were struggling to locate people's prescriptions and the pharmacist was dispensing and checking her own work. She was often being distracted and having to leave the dispensary and serve people on the counter. The pharmacy had a backlog of prescriptions awaiting to be dispensed or checked. The workbench was congested with dispensed items awaiting a final accuracy check.

There was no formal appraisal system to manage staff performance. Staff had access to trade magazines and other training material to help keep their skills and knowledge up to date. But the pharmacy's staffing profile was such that members of the pharmacy team were just about coping with the dispensing of prescriptions. Other routine tasks such as cleanliness, housekeeping, auditing of CD running balances and date checking procedures were often overlooked.

The pharmacist was expected to deliver MUR targets, but they were not pressurised to deliver targets. Meeting the targets was often not possible due to staffing levels.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises are secure. But they are not properly maintained or adequate for the services it provides.

Inspector's evidence

The front fascia of the pharmacy was adequately maintained. The pharmacy's dispensary was small, untidy, congested and disorganised. The dispensing benches were cluttered. The floor space was obstructed with boxes and bulky items. Medicines were stored haphazardly on the shelves which were dusty.

A dispensary sink was available for medicines preparation and had a supply of hot and cold water. The area around the sink was not clean and it was cluttered with paperwork, cutlery, food stuff, stock and paperwork.

The pharmacy's consultation room was advertised. But the door to this room was left open during the inspection, and the room was cluttered with paperwork and other stock items. Patient sensitive information was stored in the consultation room. A computer with a Smart card in the reader was left unattended and patient medication records could be viewed. The room was small and very basic. And it would not be possible to safely accommodate a wheelchair or a pushchair or lay a person in the recovery position, if necessary. The heating, lighting and ventilation were adequate, and the pharmacy was secured against unauthorised access when it was closed.

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

Summary findings

The pharmacy's services are accessible to most people and its team members aim to deliver these safely and effectively. The pharmacy gets its medicines from reliable sources. But it does not routinely mark prescriptions for higher risk medicines. This may mean that people do not receive all the necessary information they need to take their medicines safely.

Inspector's evidence

The entrance to the pharmacy was at street level and was step free. The retail area of the pharmacy was clear of slip or trip hazard. It could just about accommodate wheelchairs and prams. The pharmacy's opening hours and services offered were included in the pharmacy's practice leaflet. The pharmacy team members could speak to people in several languages including Punjabi and Gujarati. And used local knowledge to signpost people to other providers when a service required was not offered at their pharmacy.

The pharmacy's healthy living zone had posters displayed about cervical cancer. But there were no other healthcare leaflets available in the pharmacy.

The pharmacy offered a prescription delivery service. But signatures were only obtained from recipients for delivery of controlled drugs. Baskets were used during the dispensing process to prioritise workload and minimise the risk of prescriptions getting mixed up. Owing slips were used to provide an audit trail when the prescription could not be fully supplied. 'Checked by' boxes were initialled on the dispensing labels to show which pharmacist had been involved in the checking of the prescription. But 'dispensed by' boxes were not initialled. The pharmacy's system for storing prescriptions awaiting collection was not efficient. On the day of the inspection, members of the pharmacy team spent considerable time trying to locate people's prescriptions. This caused obvious frustration for people and quite a few chose to come back and not wait in the queue.

The pharmacy supplied medicines in multi-compartment compliance aids to approximately 50 people who had difficulties in managing their medicines. The dispenser said she had recently started compiling individual records for each person using the service. A compliance aid checked included a description of individual medicines contained within the pack. But only the 'checked by' box had been initialled. Patient information leaflets (PILs) were not routinely supplied with these compliance aids.

The pharmacist was aware of the valproate pregnancy prevention programme and said that they did not have any people within the at-risk group. The pharmacy's resource pack containing stickers, leaflets, cards and patient guides was buried under a pile of clutter. It appeared that it had never been opened. A few green stickers with 'female' scribbled had been stuck on the shelves where Epilim was stored.

Although the pharmacy had access to 'INR' stickers these were not routinely used to mark warfarin prescriptions to provide assurances that people would be provided additional advice on safe usage of their medicines. Therapeutic monitoring (INR) levels were not always recorded on a patient's medication records. A warfarin prescription awaiting collection in the retrieval section was found not

marked in any way and INR levels had not been recorded on the patient's medication record.

Prescriptions for controlled drugs not requiring secure storage were stored separately in a basket to ensure that these were not handed out to people after the prescription had expired.

Medicines were obtained from licensed wholesalers and unlicensed specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Pharmacy only medicines were stored out of reach of the public. The pharmacy had not yet implemented procedures to comply with the Falsified Medicines Directive (FMD) and did not have any of the equipment needed.

The pharmacy's date checking records were vague. There was some evidence that medicines had been date checked in the recent past but quite a few short-dated medicines that had been highlighted had not been removed from in-date stock. An item beyond its expiry date was found on the shelf. The pharmacist said she usually incorporated an expiry date check as part of her prescription checking procedure.

Medicines requiring refrigeration were not always stored between 2 and 8 degrees Celsius. Temperature records for the month of April showed that on a number of occasions the maximum temperature was at 9.5 degrees Celsius. No remedial actions had been documented. Previous months' records were not available. Members of the pharmacy team were not sure where these were kept. Medicines in the refrigerator were stored haphazardly.

All controlled drugs were stored in the CD cabinet and access was appropriately managed by the pharmacist. Bins were available to store waste medicines. But these were stored in the washroom. Denaturing kits were available to denature waste-controlled drugs.

The pharmacy had a process to deal with safety alerts and drug recalls. Records of these and the actions taken by the pharmacy team members were maintained in the pharmacy to provide an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and adequate facilities it needs to provide its services.

Inspector's evidence

The pharmacy team members had access to the internet and various reference sources. The pharmacy had a range of glass measures for measuring liquids. And it had equipment for counting loose tablets and capsules. Electrical equipment appeared to be in good working order. But the pharmacy's shredder was not working.

Access to the pharmacy’s computers were password protected. And Smart cards were seen to be in use. But these were not safeguarded against unauthorised access in the consultation room.

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.