General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Richmond Pharmacy, 57 Richmond Road, Stechford, BIRMINGHAM, West Midlands, B33 8TL

Pharmacy reference: 1101667

Type of pharmacy: Community

Date of inspection: 14/03/2024

Pharmacy context

This community pharmacy is situated in a row of shops and other services opposite a large healthcare centre which contains a GP surgery and a district nurse base. The pharmacy is open extended hours over seven days. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance aid packs to help make sure people take them at the right time.

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	1.6	Standard not met	Controlled drug records are not always appropriately maintained as per the legal requirements. Some registers have incomplete headers and sometimes entries are made before the medicine is supplied to people.
		1.7	Standard not met	Confidential waste is not always stored and destroyed correctly and NHS smartcards are used inappropriately.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.3	Standard not met	The pharmacy is not maintained to the required level of cleanliness and tidiness appropriate for the pharmacy services provided. General waste is not disposed of in a timely manner which could pose a safety risk.
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 generally manages the risks associated with its services to make sure people receive appropriate care. Its team members do not always take the correct action to protect people's private information appropriately. Members of the pharmacy team follow written procedures to make sure they work safely, and they complete tasks in the right way. They discuss their mistakes so that they can learn from them. Team members understand their role in protecting vulnerable people.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the activities of the pharmacy and the services provided. The SOPs had last been reviewed in October 2023 by the superintendent (SI). They contained some outdated references which suggested they were in need of a more thorough review. Signature sheets were used to record team member training, and roles and responsibilities were highlighted within the SOPs. The signature sheet that accompanied the October 2023 update were blank, suggesting that the pharmacy team had not read the latest version of the SOPs.

A near miss log was available. Near misses were discussed with the team member involved to help make sure they learnt from the mistake. The pharmacy team gave some examples of different types of mistakes that occurred and demonstrated some examples of how some medicines had been separated to try and avoid the same mistake happening again. The near miss log was reviewed at the end of each month using the Royal Pharmaceutical Society's review tool. The actions identified were discussed with the team. There was an SOP available for investigating dispensing incidents and the team knew the process to follow if a dispensing incident was identified.

Members of the pharmacy team were knowledgeable about their roles. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how he managed requests for codeine containing medicines. There were several new members of the pharmacy team and a work experience student, and they explained what tasks they could and could not do according to their job role. They all confirmed that they would ask a trained member of the team, or a pharmacist if they were unsure of how to undertake a task or respond to a query.

The pharmacy's complaints process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways; verbal, written, or by leaving a review online. The pharmacy team members tried to resolve issues that were within their control and involved the SI if they could not reach a solution. The pharmacy telephone was found to have been disconnected on more than one occasion during the inspection, and difficulty contacting the pharmacy by telephone had been mentioned in the online reviews. The dispensing assistants explained that this was not done intentionally and the 'end call' button had to be pressed twice to finish a call which they sometimes forgot to do. They agreed to remind the rest of the team about this to ensure that the phone line was available for people that needed to speak with the pharmacy team.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice was clearly displayed. The wrong pharmacist's details were displayed initially, but this was promptly

rectified. The RP log met requirements. There were some issues identified with the controlled drug (CD) registers. Some of the headers within the register were incomplete so it may make it harder to identify which CD the register is related to. And a random balance check did not correspond with the balance recorded in the register. Private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and sent to an external company for secure disposal. Some of the collections had been delayed as access to the bins had been blocked by a parked vehicle. Some patient information was found in black bin bags in the back yard of the pharmacy, next to the pharmacy's commercial waste bins. The back yard was accessible to the public. The pharmacy team members had their own NHS smartcards. The smartcard belonging to the SI was being used but he was not present. His access code was written on the smartcard which allowed team members to log into the NHS system in his absence. The card was removed during the inspection and the team were reminded that they should only be used by the named individual.

The RP had completed the Centre for Pharmacy Postgraduate Education (CPPE) training on safeguarding, and a dispensing assistant correctly explained what safeguarding meant, gave examples of what would indicate a safeguarding concern and what next steps to take.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has employed enough team members to generally manage the workload and the services that it provides. But there is a high turnover of staff, and this puts additional pressure on the existing team members and some tasks may be overlooked as others are prioritised. The team members plan absences in advance, so the pharmacy has enough cover to provide the services. They work well together, and they can raise concerns and make suggestions.

Inspector's evidence

The pharmacy team comprised of the SI, a locum pharmacist, four dispensing assistants, a trainee dispensing assistant, a trainee medicine counter assistant, a work experience student, several pharmacy students and home delivery drivers. The trainee dispensing assistant had worked at the pharmacy for a week, and the trainee medicine counter assistant for a month. Both were still working their probationary periods so had not been enrolled on accredited training courses. The work experience student was on a placement from college and had worked at the pharmacy for four hours a week for nearly a year. She had not been enrolled on an accredited training course and explained that she did general shop keeping tasks such as tidying, cleaning and date checking the shop floor stock, and observed other staff members.

Annual leave was requested in advance and changes to the rota were made in advance when people were on holiday. A dispensing assistant had been working at the pharmacy for many years and supported the SI with the running of the pharmacy. She assisted and guided other members of the team with their tasks and answered questions from them. This meant that she was often multitasking, and she said that she received telephone calls from the team when she was at home in the evenings and weekends when they had a question. The turnover of pharmacy staff, the number of trainees and students, and inexperience meant that there was sometimes a delay in responding to a request from someone using the pharmacy whilst the team member telephoned a more experienced team member that was not present.

The pharmacy team worked well together during the inspection and were observed helping each other and were seen moving from their main duties to help with more urgent tasks when required. The pharmacy staff said that they could raise any concerns or suggestions with any of the pharmacists and felt that they were responsive to feedback. Team members said that they would speak to other members of the team, their college tutor, or GPhC if they ever felt unable to raise an issue internally. The RP was observed making himself available throughout the inspection to discuss queries with people and giving advice when he handed out prescriptions, or with people on the telephone. Targets for professional services were not set.

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

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. Some areas of the pharmacy are less well maintained which detracts from the professional image. It has an adequate consultation room, so that people can speak to the pharmacist in private when needed.

Inspector's evidence

The pharmacy was an adequate size for the services provided, although storage space for completed prescriptions was lacking. This made it difficult for the pharmacy team to locate some prescriptions and had to empty large boxes which then blocked the floorspace in the dispensary and became a trip hazard. The premises had been extended over the years to provide more space in the dispensary. Dispensing and checking activities took place on separate areas of the worktops. There were multiple lever-arch folders taking up space on the dispensary workbenches that could be archived as they contained old paperwork and training materials belonging to ex-employees which would help create more space. There was dust and some loose tablets underneath the folders, suggesting they were not removed when the work benches were cleaned. There was a secure shipping container in the garden which provided additional storage for pharmacy consumables.

The back of the dispensary was filled with empty cardboard boxes and black bin bags. These were up to ceiling height and blocked access to part of the dispensary. The back door was behind the boxes; however, this did not appear to be a fire exit and the shipping container prohibited a clear path away from the premises. The team explained that the commercial waste bins had not been collected as a vehicle had parked in the access road which had blocked access to the bin collection lorry. But a member of the team cleared all this rubbish during the inspection so there was space to put it out. This detracted from the professional image of the pharmacy, and was also a staff safety and hygiene risk.

The pharmacy was cleaned by members of the pharmacy team. Hot and cold running water, hand towels and hand soap were available. The staff bathroom was upstairs, and that part of the building belonged to the café next door. The bin in the bathroom was overflowing with used hand towel, and the bathroom would benefit from a thorough clean. Any maintenance issues were reported to the SI. The pharmacy had air conditioning and the temperature in the dispensary felt comfortable during the inspection. Lighting was adequate for the services provided.

There was a private soundproof consultation room which was signposted. There were some black bin bags on the floor in the consultation room, this detracted from a professional image. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers healthcare services which are easy for people to access. It generally manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. The pharmacy does not store some of its stock properly, and issues with the pharmacy's controlled drug procedures require attention.

Inspector's evidence

The pharmacy had a step-free access from the pavement and a member of staff was available in the shop to assist people with the front door when required. A home delivery service was available when the patient could not access the pharmacy and a small amount of parking was available outside. Pharmacy staff could speak to patients in English, French and Urdu. The pharmacy's opening times had reduced and now closed at 9pm rather than 11pm. The new opening times were advertised on the pharmacy entrance and the NHS website. The old closing time was still displayed in large text on the outside of the building which may be confusing to people requiring pharmacy services in the evening.

Prescriptions were dispensed into baskets to help make sure medicines were not mixed up together. Team members signed the 'dispensed-by' and 'checked-by' boxes on medicine labels, so there was a dispensing audit trail. The team were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. Counselling materials were available to support this and supplied when necessary. Valproate containing medicines were supplied in original packaging.

Multi-compartment compliance packs were used to supply medicines to some people. Prescriptions were ordered in advance to allow for any missing items or changes to be queried with the surgery ahead of the intended date of supply. Each person had a record to show what medication they were taking and when it should be packed. Compliance packs were dispensed at the weekend as that was when the pharmacy was usually quieter.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. The date checking records could not be located , although the team said they completed a record when they had date checked a section. Various medicines were stored outside of their original containers, and some did not contain the batch number and expiry dates. There were some mixed batches of the same medicine within the same box. Stock was not always stored in an organised manner on the shelves and some medicines of the same strength had become mixed together, this increased the risk of the incorrect strength being selected. For example, diazepam 2mg, 5mg and 10mg tablets were mixed together. Split liquid medicines with limited stability once they were opened were generally marked with a date of opening, some were removed as they had limited stability once opened and had not been marked with the date that they were opened. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of

licenced wholesalers and the pharmacy was alerted to drug recalls via emails from the Medicines and Healthcare products Regulatory Agency (MHRA).

The controlled drug cabinet was secure and reaching capacity. Medicines were generally stored in an organised manner inside although some changes could be made to increase capacity. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was used for additional information when needed. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

Equipment for clinical consultations had been procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available. Computer screens were not visible to members of the public. Cordless telephones were in use, and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.