General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sood Chemists Ltd, 1B Church Road, Horfield, BRISTOL, BS7 8SA

Pharmacy reference: 1112132

Type of pharmacy: Community

Date of inspection: 26/07/2019

Pharmacy context

This is a community pharmacy located next door to a GP surgery in a residential area of Bristol. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews and the New Medicine Service (NMS). The pharmacy supplies medicines inside multi-compartment compliance aids if people find it difficult to manage their medicines. And it supplies medicines to residents within care homes.

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

Overall, the pharmacy manages most risks in a satisfactory manner. It has written instructions to help with this. Pharmacy team members deal with their mistakes responsibly. And, they understand how to protect the welfare of vulnerable people. But, the instructions have not been reviewed recently. This increases the chance that team members may not be completing their tasks in the best or most up-to-date way. Pharmacy staff are not always recording all the details when mistakes happen or formally reviewing them. So, this could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening. And, although the pharmacy adequately maintains most of the records that it must, it is not always recording enough detail in accordance with the law.

Inspector's evidence

The pharmacy was organised, its work spaces were kept clear of clutter and it was currently operating using two regular locum pharmacists. The workload was manageable and team members were up to date with this. There were documented standard operating procedures (SOPs) available to support the services. Staff had read and signed the SOPs. Roles and responsibilities for the team were defined within these and staff were aware of their responsibilities and limitations. In the absence of the responsible pharmacist (RP), staff knew which activities were permissible and they knew the procedure to take, if the pharmacist failed to arrive.

However, the SOPs were last reviewed in 2016 and were marked for review in 2018. There was no information available to show that they had been reviewed since then. In addition, the inspection took place in the afternoon and an incorrect RP notice was on display. This meant that people were provided with incorrect details about the pharmacist in charge at the time. This was discussed with the RP at the time.

Pharmacists and staff worked in segregated areas and there was evidence that staff were recording details about their near misses. However, there were gaps within this where staff had not recorded information about the learning points or any additional contributing factors that may have caused the situation. The near miss log was previously signed by the last regular pharmacist to indicate that near misses had been collectively reviewed by them, however, there were no other documented details about the review or evidence that this had occurred since this period.

Incidents were handled by the pharmacists and the process was in line with the GPhC's expectations. There was a documented complaints process and details about previous incidents were present, this included incidents that were reported to the National Reporting and Learning System although there was no information about the most recent incidents described by staff. There was no information on display to inform people about the pharmacy's complaints procedure or about how it maintained people's privacy.

The team segregated confidential waste before it was disposed of through an authorised carrier and staff described using the consultation room for private conversations with people. Dispensed prescriptions awaiting collection were stored within the dispensary, this meant that sensitive details were not visible from the retail area. The team had signed confidentiality agreements and staff were aware of the EU General Data Protection Regulation (GDPR).

Staff were trained to identify signs of concern to safeguard vulnerable people and they referred to the RP in the first instance. The pharmacist thought that he was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE) but could not remember when this occurred. There were relevant local contact details, an SOP was available as guidance and the pharmacy's chaperone policy was on display.

Records of the maximum and minimum temperature were maintained to verify that medicines requiring cold storage, were appropriately stored. A full record of controlled drugs (CDs) brought back by the public for destruction was maintained. The pharmacy's professional indemnity insurance was through the National Pharmacy Association (NPA) and due for renewal after 26 February 2020.

A sample of registers checked for controlled drugs and records of emergency supplies were documented in line with statutory requirements. For CDs, balances were described as checked and documented every few weeks. On randomly selecting two CDs held in the cabinet, the quantities held matched the balances recorded within the corresponding registers.

The electronic RP record showed gaps where pharmacists had failed to record the time that their responsibility ceased. Incorrect prescriber details, including names of prescribers and their addresses as well as incorrect types of prescribers (doctor's details instead of a dentist's for example) were seen recorded in the electronic private prescription register. There were also missing details within records of unlicensed medicines. This included prescriber information, the date of dispensing and details of the person who was supplied the unlicensed medicine.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The pharmacy's team members understand their roles and responsibilities. They are provided with resources to complete ongoing training. This helps to ensure that their skills and knowledge are kept up to date.

Inspector's evidence

The pharmacy dispensed approximately 7,000 prescription items every month with 103 people receiving their medicines inside multi-compartment compliance aids, two care homes were supplied medicines for around 15 residents and there were four people receiving medicines via instalment prescriptions. In addition to the Essential Services, the pharmacy provided MURs, the NMS and seasonal flu vaccinations. There were no formal targets set for the locum pharmacist to complete services.

Staff at the inspection included a locum pharmacist, the manager who stated that she was accredited through the grandparent clause, a medicines counter assistant (MCA) and dispensing assistant. There were also another two dispensing assistants and another MCA. One of the dispensing assistants delivered medicines and the manager explained that she was responsible for taking care of administration, ordering and putting stock away. Staff covered each other as contingency for absence or annual leave. The MCAs and dispensing assistants were trained through accredited routes. The team's certificates of qualifications obtained were not seen.

Team members asked relevant questions before selling medicines over the counter (OTC). They referred to the RP when unsure or when required and held a suitable amount of knowledge of OTC medicines. To assist with training needs, the team described reading available literature, online resources were used, this included completing training through virtual outcomes and using training books from wholesalers. Staff progress was described as monitored regularly but informally. They were a small team, so the staff discussed relevant information verbally and planned their tasks and priorities daily.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment for the delivery of its services.

Inspector's evidence

The pharmacy premises consisted of a medium sized, spacious retail area and dispensary. There was a section available to store multi-compartment compliance aids in the latter, a small storage area at one end of the dispensary with staff kitchenette and staff WC facilities located here. A signposted consultation room was available for private conversations and services. The room was unlocked, it was of a suitable size to conduct services. However, there was confidential material stored here as dispensed medicines were placed within crates and previous records (such as CD registers) were stored within unlocked cabinets. Once highlighted, the team removed the crates and started looking for a key to keep the room locked in future.

The pharmacy was suitably lit and well ventilated, the retail space was professional in appearance and all areas were clean. Pharmacy (P) medicines were stored behind the front counter and staff were always within the vicinity. This helped restrict these medicines being self-selected.

Principle 4 - Services ✔ Standards met

Summary findings

In general, the pharmacy provides its services safely and effectively. It obtains its medicines from reputable sources and stores them appropriately. Members of the pharmacy team can make adjustments to allow people with different needs to access their services. But, they don't always identify, make relevant checks or record information when people receive higher-risk medicines. This makes it difficult for them to show that appropriate advice has been provided upon supply. And, they sometimes leave filled multi-compartment compliance aids unsealed overnight, which can add extra risk to the process.

Inspector's evidence

Entry into the pharmacy was at street level from an automatic front door, there was some clear, open space inside the premises and wide aisles. This meant that people requiring wheelchair access could easily use the pharmacy's services. Staff described using written communication for people who were partially deaf, they used representatives for people who were visually impaired and could speak Polish, Hindi, Punjabi and Urdu if required. The manager was observed conversing in the latter with one member of the public who attended the pharmacy. The pharmacy's opening hours were listed on the door. There were two seats available for anyone wanting to wait for their prescription and some leaflets available about other services. Staff could also signpost people to other organisations from documented information that was present and from their own knowledge.

The team used baskets to hold prescriptions and medicines to prevent any inadvertent transfer. Colour co-ordinated baskets identified priority. Staff involvement in processes was apparent through a dispensing audit trail that was used. This was through a facility on generated labels.

Staff were aware of the risks associated when valproate was prescribed to patients at risk and there was literature available to provide to people, upon supply of this medicine. Prescriptions for people prescribed high-risk medicines were not marked in any way that would enable pharmacist intervention or relevant checks to be made. There were no details recorded to verify whether any checks had been made, this included information about the International Normalised Ratio (INR) level for people prescribed warfarin.

Dispensed medicines awaiting collection were stored with prescriptions held in a retrieval system. The team could identify fridge items and CDs (schedules 2 and 3) as this information was highlighted. Uncollected medicines were removed every month. Schedule 4 CDs were not identified, routinely identifying all CDs as best practice was discussed during the inspection as some members of the team may not have recognised them as prescriptions for CDs or their 28 day prescription expiry.

Multi-compartment compliance aids:
The initial setup for people receiving compliance packs involved the person's GP initiating and assessing suitability for them. Prescriptions were ordered by the pharmacy and cross-checked when received, against people's individual records. If changes were identified, staff confirmed them with the prescriber and documented the details on their records. Descriptions of the medicines within the compliance aids were provided. All medicines were de-blistered into them with none left within their outer packaging. Patient information leaflets (PILs) were supplied routinely. Mid-cycle changes involved

retrieving the compliance aids, amending, re-checking and re-supplying them. They were sometimes left unsealed overnight but banded together with an elastic band. People receiving compliance aids that were prescribed warfarin received this separately, there were no relevant checks made about INR levels and no details were seen documented about this.

Care home dispensing:
Medicines were provided to the homes as compliance aids. They ordered repeat prescriptions and the pharmacy was provided with duplicate copies of the requests, prescriptions were checked against this to ensure all items had been received. Details about missing items were conveyed to the care home if items were outstanding. Interim or mid-cycle medicines were dispensed at the pharmacy. PILs were routinely supplied and descriptions of the medicines inside the compliance aids were provided. There were no residents prescribed higher-risk medicines. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents.

Delivery service:
The pharmacy delivered medicines to people's homes and maintained records to verify this. CDs and fridge items were highlighted and checked prior to delivery. Failed deliveries were brought back to the pharmacy with notes left to inform people about the attempt made and medicines were not left unattended. Signatures from people were obtained when they were in receipt of their medicines. There was a risk of access to confidential information from the way people's details were laid out when signatures were obtained. However, staff explained that they were told to cover the details during this process.

The pharmacy obtained medicines and medical devices from licensed wholesalers such as Alliance Healthcare, Sigma, Colorama and AAH. Colorama was used to obtain unlicensed medicines. Staff were aware of the process involved with the European Falsified Medicines Directive (FMD). The pharmacy was registered with SecurMed, there was relevant equipment present and the team was complying with the process, where possible.

Medicines were stored in an organised manner. There were no date-expired medicines present or mixed batches and short-dated medicines were identified using stickers. A date-checking schedule was in place, medicines were date-checked for expiry every three months. The MCA had created her own booklet to record details about date checks. Liquid medicines with short stability, were marked with the date that they were opened. CDs were stored under safe custody. Keys to the cabinet were maintained during the day and overnight in a manner that prevented unauthorised access. Medicines were stored evenly and appropriately within the medical fridge. Drug alerts were received by email, stock was checked, and action taken as necessary. This included passing alerts to the homes if they had received any affected stock. An audit trail was available to verify this process.

The pharmacy used appropriate containers to hold medicines brought back by people for disposal. They were collected in line with its contractual arrangements. However, there was no list for the team to identify hazardous and cytotoxic medicines. People bringing back sharps to be disposed of, were referred to the local council. Returned CDs were brought to the attention of the RP, details were entered into the CD returns register, they were segregated and stored in the CD cabinet prior to destruction.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities it needs to provide services safely.

Inspector's evidence

The pharmacy was equipped with a range of current reference sources. The team had access to a range of equipment to provide pharmacy services. This included counting triangles and a range of clean, crown stamped, conical measures for liquid medicines. The dispensary sink used to reconstitute medicines was relatively clean there was hot and cold running water available with antibacterial hand wash present. The blood pressure machine was described as recently replaced. The CD cabinet was secured in line with statutory requirements. Medicines requiring cold storage were stored at appropriate temperatures within medical fridges.

Computer terminals in the dispensary were positioned in a manner that prevented unauthorised access. There were cordless phones to enable staff to hold private conversations away from the retail space if needed. Staff used their own NHS Smartcards to access electronic prescriptions, they took them home or stored them securely overnight.

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.