General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Integro Pharmacy, Unit 4 The Alpha Centre, North Lane, ALDERSHOT, Hampshire, GU12 4RG

Pharmacy reference: 1120906

Type of pharmacy: Community

Date of inspection: 30/06/2021

Pharmacy context

This is a closed pharmacy which is independently run. It is in a warehouse unit on an industrial park in Aldershot. It dispenses prescriptions for people in care environments and for a small number of people in the community. It supplies medicines in multi-compartment compliance packs. And it provides a delivery service. The inspection was conducted during the COVID-19 pandemic.

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

In general, the pharmacy has adequate procedures to identify risk. It has written procedures in place to help ensure that its team members work safely. And it has insurance to cover its services. The pharmacy team has adapted its working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. And it knows how to protect the safety of vulnerable people. In general, the pharmacy protects people's private information and it keeps the records it needs to. But it is not thorough enough in ensuring that it keeps all of its records the way it should.

Inspector's evidence

The pharmacy was closed to the public. And the only visitors to the pharmacy were delivery drivers. The pharmacy had placed hand sanitiser at different locations in the pharmacy for the team to use. The team had a regular cleaning routine and had access to personal protective equipment in the form of gloves and masks.

The pharmacy's main service was dispensing prescriptions and delivering them to people who lived in care environments. This included nursing and care homes and the residents of a local school for children with additional caring needs. In general, it recorded its mistakes and reviewed them periodically. The responsible pharmacist (RP) was a locum who worked at the pharmacy on a regular part-time basis. And she agreed that she and her dispenser colleagues would ensure that mistakes were recorded and discussed with the team regularly. She recognised that it was important to learn as much as possible from mistakes to help prevent them from happening again. It was agreed that records should identify what could be done differently next time to prevent mistakes and promote continued improvement. The pharmacy had standard operating procedures (SOPs) in place. But team members had deviated slightly from procedures when storing stock after dispensing. The RP agreed that retraining was required and a review of the team's compliance with dispensing procedures. During the inspection the RP placed her RP notice on display showing her name and registration number as required by law.

People could give feedback on the quality of the pharmacy's services. The pharmacy's website gave details of the pharmacy's complaints procedure. And it provided information on how people could contact the team if they had any queries or were experiencing problems with the service. In general, the team sought feedback from conversations with people as well as staff at the homes and the school it supplied medicines to. The pharmacy had not conducted a formal feedback survey over the last year due to the pandemic. But in general, the pharmacy team had received many positive comments from people. It had received positive comments from people who were grateful that they did not have to visit the pharmacy to get their medicines ordered or delivered. Particularly when they had been shielding or were unwell. During the pandemic the pharmacy also conducted regular meetings over 'Zoom' with staff at the homes and school. It did this to try to maintain a good relationship with them. And to ensure that any issues could be addressed, at a time when the pharmacy's team members were unable to visit in person.

The pharmacy's website provided details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. But customer concerns were generally dealt with at the time by the regular pharmacists. The pharmacy had professional indemnity and public liability

arrangements so it could provide insurance protection for the pharmacy's services and its customers. It had professional indemnity and public liability insurance in place until 12 September 2021. It is understood that when this date is reached the pharmacy will renew its insurance arrangements for the following year. In general, the pharmacy kept its records in the way it was meant to. This included records for emergency supplies, the RP record, and controlled drugs (CDs). But team members were unable to locate the pharmacy's private prescription records. The inspector discussed the importance of maintaining the pharmacy's essential records with the RP and pharmacy manager. The RP and pharmacy manager recognised that the pharmacy should ensure that all of its essential records are kept in the way they should be.

The pharmacy's team members understood the need to protect people's confidentiality. Confidential paper waste was discarded into separate white waste bags. And it was collected regularly for confidential destruction by a licensed waste contractor. People did not generally enter the pharmacy, so people's prescription details could be kept secure. The RP and the dispenser had completed appropriate safeguarding training. Other team members had been briefed. And they knew to report any concerns to the RP. The team could access details for the relevant safeguarding authorities online. But it had not had any specific safeguarding concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages its workload safely and effectively. And team members support one another. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

At the time of the inspection the RP was working alongside the pharmacy manager, who was also a dispensing assistant, two further dispensing assistants and two dispensing assistants who were in training. The pharmacy also had a pharmacy graduate and a workplace student working on the day of the inspection. In general team members had read all the relevant SOPs. Except for the workplace student who was under the supervision of other team members. Those who were in the early stages of their training, including the pharmacy graduate, were in the process of reading through the SOPs. The inspector, RP and pharmacy manager discussed the importance of ensuring that team members only undertook tasks they were trained to do. The RP accepted that the whole team would benefit from refreshing their understanding of the pharmacy's procedures. The pharmacy had carried out an informal risk assessment for its individual team members but had not had to make any special adjustments for anyone.

The pharmacy was busy at the time of the inspection. But the RP and pharmacy manager were seen to work effectively together. The pharmacy had a close-knit team who worked regularly together. The RP shared pharmacist responsibilities with another regular locum. And the superintendent (SI). And they covered shifts between them. Pharmacists were supportive of one another. And they were also able to raise any concerns with the SI. The daily workload of prescriptions was in hand and customers were attended to promptly. The RP was able to make her own professional decisions in the interest of patients. And team members could raise concerns with the SI, RP and their colleagues if they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. They are generally organised. And they are sufficiently clean and secure.

Inspector's evidence

The pharmacy was in a warehouse unit on an industrial park. It had a delivery shutter and a staff door to the side. The pharmacy had installed an additional panel with a normal door across the delivery entrance for staff and delivery drivers to use. Inside the pharmacy had a large dispensing area and a delivery and collection area. The dispensing area had four separate work surfaces for dispensing and a separate work surface for accuracy checking. The pharmacy also had a separate room for dispensing urgent prescriptions. And it stored most of its antibiotics here.

The team cleaned the pharmacy regularly to ensure that contact surfaces were clean. And stock on shelves was stored tidily. But floors and some work surfaces were cluttered. The pharmacy had staff facilities in a separate area away from the main dispensary. The RP agreed that the pharmacy as a whole should be kept tidy and free of clutter and that this would provide a more professional appearance. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. And makes them adequately accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy generally stores its medicines properly. But it does not do enough to ensure that all medicines are packed and labelled correctly when it puts them back into stock.

Inspector's evidence

The pharmacy's website gave its times of opening. And a description of its services. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them. It delivered prescriptions across the UK but the majority of people using its services lived within the local area. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It provided multi-compartment compliance packs for people living at home who needed them. And for people living in care home and nursing home environments. The compliance packs used for many people in nursing homes and care homes involved the dispensing of medicines into individual pods. Each pod was labelled with the person's name, the name of the medicine and the time and date the medicine was to be taken. The labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. And patient information leaflets (PILs) were supplied with new medicines and generally with regular repeat medicines. The RP gave people advice on a range of matters. And would give appropriate advice to anyone taking high-risk medicines. The RP had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines. But no-one taking it was in the at-risk group. The RP was aware of the precautions she would need to take, and counselling she would give, if it were to be prescribed for someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines, appropriately and in their original containers. But the inspector found two packs containing mixed brands of tablets. This meant that the outer packaging did not give an accurate description of the tablets inside it, including the tablets' expiry date. The inspector discussed this with the RP, and it was agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing. Stock on the shelves was generally tidy and organised. The pharmacy team date-checked the pharmacy's stocks regularly. And they kept records to help them manage the process effectively. A random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted. And the team put its out-of-date and patient returned medicines into dedicated waste containers. The team stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures to ensure that the medication inside was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls. A previous recall for Clonidine liquid in February had prompted the team to retrieve any of the affected batch from people.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies.

The pharmacy had several computer terminals which had been placed at individual work- stations around the pharmacy. Computers were password protected. And team members understood that they had to use their own smart cards when working on PMRs, so that they could maintain an accurate audit trail and ensure that access to patient records was appropriate and secure.

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.