General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: DB Raval Ltd, 23 Eaton Place, Bingham, Nottingham, NG13 8BD

Pharmacy reference: 9010626

Type of pharmacy: Community

Date of inspection: 23/03/2023

Pharmacy context

This pharmacy is in the centre of Bingham, a market town in Nottinghamshire. Its main services include dispensing NHS prescriptions and selling over-the counter medicines. It supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a delivery service to people who are unable to visit the pharmacy in person.

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	The pharmacy does not maintain all of its records accurately. And it does not enter information into records in a timely manner as required by law.
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 not all met	4.3	Standard not met	The pharmacy does not store and manage all its medicines as it should and in accordance with legal requirements. And it does not manage its waste medicines appropriately.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not adequately manage all risks associated with providing its service as it does not maintain all records it must by law. Team members do not always have access to complete written procedures to help them provide services in a consistent way. They keep people's confidential information secure. And they have the knowledge they need to help protect vulnerable people. Pharmacy team members act openly and honestly by discussing their mistakes. And they understand how to respond to feedback they receive about the pharmacy and its services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. But these were unavailable for inspection as the Superintendent Pharmacist (SI) had removed them from the premises to review them. The SI explained that electronic access to the templates used to personalise the SOPs for use in the pharmacy were available. And the SI provided the SOPs for inspection shortly after the physical inspection. A pharmacy student who had commenced their role recently explained they had accessed the electronic SOP templates to support their learning. But these templates were not tailored for use in the pharmacy. For example, information associated with key contacts to support the management of controlled drugs was not available on the standard templates. A discussion during the inspection highlighted the need for SOPs to be available at all times within the pharmacy premises to support team members in their role. Pharmacy team members demonstrated a good understanding of their job roles through discussing and demonstrating the tasks they undertook. One team member discussed the tasks that they could not complete if the responsible pharmacist (RP) took absence from the premises.

The pharmacy had processes for managing mistakes that were identified during the dispensing process, known as near misses. Following a mistake being identified by a pharmacist, team members checked their work again and corrected the mistake. They regularly discussed their mistakes to share learning. But they did not always take the opportunity to record the mistake to support the identification of trends. The team had acted to reduce risk following near misses. For example, separating amlodipine and amiloride on the dispensary shelves due to the two medicines sounding alike and looking similar. The team had also ensured both medicines were stored separate to amitriptyline following learning from a national patient safety briefing. The pharmacy had a process for reporting mistakes identified following a medicine being supplied to a person, known as dispensing incidents. This involved recording the mistake through an electronic reporting tool. Team members were keen to share examples of the actions they took to reduce risk using learning from national patient safety briefings. For example, the pharmacy kept original packaging following supplying medicine in multi-compartment compliance packs. This supported it in answering any queries and responding to any concerns raised about medicines, such as a patient-level drug recall.

Pharmacy team members understood how to respond to and manage any feedback they received from members of the public or other healthcare providers. But the pharmacy didn't advertise how people could provide feedback. It was clear that the pharmacy prioritised the needs of people using its services. And this had been recognised at a local awards event where the pharmacy had received an award for going above and beyond to assist the residents of the town. The pharmacy was committed to

safeguarding vulnerable people. And team members provided several examples of concerns that they had raised to help protect vulnerable people. A pharmacy team member discussed learning they had completed to assist them in recognising and reporting safeguarding concerns. Pharmacists had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). The team was aware of both the 'Safe Space' and 'Ask for ANI' safety initiatives, designed to protect people suffering domestic abuse.

The pharmacy protected people's personal information by holding it within staff-only areas of the premises and on password protected computers. It held confidential waste in designated sacks, and these were sealed and collected for secure disposal periodically. The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. The legal records the pharmacy was required to keep by law were not kept up to date. Entries in the controlled drug (CD) register associated with the receipt and supply of solid dose formulations had not been made for several weeks. Physical checks of stock against the running balance recorded in the register were infrequent. Entries in the RP register had not been made for the same period of time. And the pharmacy had a backlog of private prescriptions waiting to be entered in its Prescription Only Medicine (POM) register. The pharmacy had a patient returned CD register but returns found within its secure cabinets dated back to 2017 and many of the returns had not been entered into the register at the time of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small, dedicated team of people who support each other in their work. And team members focus on providing people with a good level of care. They understand how to raise concerns at work. And they engage in some ongoing discussions to share ideas and learning. But when the pharmacy experiences some workload pressure it falls behind with some key tasks.

Inspector's evidence

The pharmacy had experienced some turnover of team members in recent months. On duty was the SI undertaking the role of RP, a second pharmacist, a pharmacy student, and a trainee dispenser. The pharmacy also employed a qualified medicine counter assistant and an apprentice had recently started a role as a trainee dispenser. Two pharmacists worked most days. The pharmacy was currently advertising for an additional two team members to fill vacancies for a medicine counter assistant and a dispenser. The SI explained that the staffing pressures had impacted their ability to keep up to date with record keeping. The situation had improved with the employment of the pharmacy student and trainee dispenser. But the current vacancies meant it could be more difficult for the pharmacy to cover periods of staff leave.

The trainee dispenser felt supported in their role and had access to the pharmacy's computer to support their learning. The apprentice was enrolled on a GPhC accredited learning course to support them in their role. One of the resident pharmacists had completed learning associated with the COVID-19 vaccination programme prior to being directly involved in the service. Pharmacy team members engaged in some ongoing learning at work through reading articles and information to support them in their roles. But they did not benefit from a structured appraisal process to monitor their learning and development needs. The pharmacy did not set specific targets related to its services. The team's focus was on providing positive experiences for people to support their health needs. Team members discussed topics such as patient safety and the management of workload during daily conversations. Pharmacy team members felt confident in sharing feedback and in raising a concern at work if the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy premises are clean, secure, and suitable for the services provided. The pharmacy has facilities to allow people to have a private conversation with a member of the pharmacy team. But some areas are somewhat cluttered, and this increases the risks of mistakes.

Inspector's evidence

The pharmacy was secure against unauthorised access, and it was clean. The public area and consultation room were organised and professional in appearance. The consultation room offered a suitable space for people to speak to a member of the pharmacy team in private. The dispensary required some attention as work benches and floor spaces were cluttered. The team made efforts to store items at floor-level against workbenches to reduce the risk of them causing a trip or fall. The items included wholesaler totes containing out-of-date medicines and stacked baskets containing empty packaging associated with the management of the multi-compartment compliance pack service. To the side of the dispensary was an area which provided staff facilities. Despite the pharmacy moving into the premises six years ago this area had yet to be finished. The pharmacy used local tradespeople to manage any maintenance concerns. Other than the unfinished area there was no outstanding maintenance issues reported. Lighting and heating arrangements were appropriate. Sinks were equipped with antibacterial soap and towels and there was hand sanitiser available for use.

The dispensary was an appropriate size for the level of activity carried out. But the amount of workspace available was impacted by paperwork and other items. Team members were observed using the available workspace safely. A workbench at the front of the pharmacy used to process acute prescriptions was relatively clear and the pharmacist had a protected area for checking assembled medicines. The team also used a dedicated area at the back of the dispensary for workload associated with supplying medicines in multi-compartment compliance packs.

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

Summary findings

The pharmacy does not store all its medicines as it should. And it does not have the sufficient processes to support it in managing waste medicines safely. The pharmacy's services are accessible to people. And they manage them safely. People benefit as a pharmacist is readily available to discuss their health.

Inspector's evidence

The pharmacy was accessible to people through a door leading from street level. It was within a pedestrian zone with free parking close by. It displayed details of its opening times. Pharmacy team members knew to signpost people should the pharmacy be unable to provide a service or supply a medicine. They felt they had a good working relationship with the local surgery. And provided examples of how this benefitted the people using healthcare services in the town. For example, the team regularly provided feedback to surgery staff about out-of-stock medicines to support prescribing decisions.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. And both pharmacists had good supervision of the medicine counter from the dispensary. Pharmacists regularly counselled people about their medicines and answered any questions they had. The pharmacy's delivery service was pharmacist led. This meant people who struggled to visit the pharmacy in person were able to speak to a pharmacist face-to-face. There was a diary to support managing this service, this provided an audit trail of the deliveries made. The SI demonstrated some intervention notes that they recorded on people's medication record (PMR). This supported the team in providing person centred care when speaking to people. Pharmacy team members had an awareness of the valproate pregnancy prevention programme (PPP). A recent audit had identified that the pharmacy did not currently supply valproate to people within the at-risk group. It had the necessary resources and tools in the event it received a prescription for a person in the at-risk group. The pharmacy team checked the prescriptions towards the end of each working day. It then contacted people who had not attended to collect urgent prescriptions such as antibiotics to inform them of the pharmacy's closing time and to check they were able to attend to collect their medicine. This supported people in receiving urgent medicines without delay.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. It kept original prescriptions for medicines it owed to people. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The SI led the multi-compartment compliance pack dispensing service. They used the PMR to record details of changes associated with the service. And the pharmacy kept a record of a person's current medicine regimen including the times of day they took each medicine. The pharmacy kept robust audit trails for this service including photographs of assembled compliance packs and it kept original packaging used to fill the packs. This supported it in managing queries associated with the service. The photographs were stored on a password protected device and were deleted regularly. The compliance packs contained clear labelling and patient information leaflets were supplied at the beginning of each dispensing cycle.

The pharmacy sourced medicines from licensed wholesalers. It stored most medicines in an orderly manner, in their original packaging throughout the dispensary. But not all medicines subject to safe custody requirements were stored correctly due to limited space. There was a significant amount of out-of-date medicines waiting for secure destruction. This limited space for stock medicines severely. The pharmacy had two medical fridges for medicines requiring cold storage. The fridges were an appropriate size for the amount of medicines stored inside. But temperature records were not maintained to date. Thermometers were within the accepted temperature range during the inspection, as were the minimum and maximum temperatures on both thermometers. But the omission of records meant it was more difficult for the team to demonstrate that these medicines had been stored within the correct temperature range.

Pharmacy team members completed date checking tasks but there was no current record to support the team in monitoring the frequency of these checks. A random check of stock found an out-of-date medicine in the dispensary and some out-of-date adrenaline ampules in the consultation room. Team members were observed checking expiry dates during the dispensing process to reduce the risk of supplying an out-of-date medicine. The pharmacy had medicine waste receptacles, CD denaturing kits and sharps bins available to support the team in managing pharmaceutical waste. But there was a large overage of medicine waste waiting to be disposed of. This was held in a corner of the dispensary, close to in-date stock, and made it difficult for team members to access some shelves when storing and picking stock medicines. And some wholesaler totes in the dispensary contained out-of-date stock waiting for disposal. The pharmacy received drug alerts and recalls by email. And it kept evidence of these alerts. The team had acted upon the most recent alert in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And pharmacy team members use the equipment in a way which protects people’s confidentiality.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources available including the British National Formulary (BNF). They had internet access to support them in resolving queries or obtaining up-to-date information. And they used password protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicine out of direct view of the public area. This prevented personal information on bag labels and prescription forms being seen by unauthorised people. Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. Its blood pressure machine was from a recognised manufacturer. Electrical equipment was in working order and cables and plugs were visibly free from wear and tear.

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.