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: 24/10/2023

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. The pharmacy provides COVID and flu vaccination services. 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 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 identifies and manages the risks associated with its services effectively. It keeps people's confidential information secure, and it mostly keeps its records as required by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns to help protect vulnerable people. They know how to manage feedback and they engage in regular conversations and learning following mistakes they make during the dispensing process to help reduce risk.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The Superintendent Pharmacist (SI) had reviewed these in March 2023. Pharmacy team members demonstrated a good understanding of their job roles through discussing and demonstrating the tasks they undertook. And they had signed SOPs relevant to their roles to confirm they had read and understood them. A 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. A team member provided examples of how they regularly discussed their mistakes to share learning. The team recorded some of these mistakes in a near miss record. The SI acknowledged that sometimes the opportunity was not taken to formally record a mistake, particularly if the pharmacy was busy. The team regularly acted to reduce risk following near misses. For example, they separated medicines with similar names and held these in different sections of the dispensary to reduce the risk of a picking error occurring. Examples seen included amlodipine and amiloride being separated and ropinirole and risperidone being separated. The team regularly shared learning from national patient safety publications. The SI demonstrated how propranolol and prednisolone were held separately after they has read a published case study about the risk of making a mistake when dispensing these medicines. They had also taken steps to store medicines used in the treatment of diabetes separately to other medicines. The pharmacy had an incident reporting procedure in the event a mistake was identified following the supply of a medicine to a person, known as a dispensing incident. The SI stated they had not needed to investigate a mistake of this nature. They provided an oversight of how they would act to investigate and report a dispensing incident.

Pharmacy team members understood how to respond to and manage feedback they received about the pharmacy or a pharmacy service. But the pharmacy did not advertise how people could provide feedback. Team members reported feedback as being largely positive. A recent mystery shopper experience had awarded the team with 100% scores for the advice and support a team member had provided. The pharmacy was committed to safeguarding vulnerable people. The SI provided several examples of concerns they had raised to help protect vulnerable people. And another example of how they had acted to reassure a person who had reached out for support. Pharmacy team members had completed some learning to assist them in recognising and reporting safeguarding concerns. Pharmacists had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy had contact information for local safeguarding teams available and the SI discussed how they would offer a safe space to people using code words associated with safety

initiatives, designed to protect those people who may experiencing 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 current indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. The RP record, records of private prescriptions dispensed and records to support the supply of unlicensed medicines to people were kept up to date. Most sections of the controlled drug (CD) register showing the receipt and supply of CDS were kept up to date. And there was evidence of regular balance checks taking place. But records for two sections of the register were not up to date and one of the random physical balance checks completed during the inspection did not correspond to the balance recorded in the CD register. The SI explained this was due to some recent pressure on workload. The SI acted to bring the record up to date immediately after the inspection and evidence of this was provided to the inspector. They also provided assurance of how they would keep the records up to date going forward. The pharmacy had a patient-returned CD register and it recorded returns at the time of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small, dedicated team of people. Team members work together well and focus on providing people with a good level of care. They engage in some ongoing discussions to share learning. They feel supported, and they know how to raise a concern at work.

Inspector's evidence

On duty was the SI undertaking the role of RP, a pharmacy student, and a medicine counter assistant. Another pharmacist also worked at the pharmacy most days during school hours alongside the SI. The pharmacy also employed a trainee dispenser and was starting the recruitment process for an additional team member following a team member very recently leaving. The pharmacy used an experienced locum pharmacist to cover absence when required. The pharmacy was busy with lots of requests for services such as repeat prescription ordering, deliveries, and stock queries during the inspection. It was up to date with its workload, with acute prescriptions prioritised to ensure people received their medicine in a timely manner. The pharmacy did not set any targets which its team members were required to meet.

Pharmacy team members felt supported in their role, and they explained that ongoing learning took place through asking questions and exploring case studies. For example, the pharmacy student would share case studies from university, and pharmacists shared examples of their own learning with the team. Team members worked together well, and they engaged in monthly briefings designed to share feedback and reduce risk. The SI reported that the trainee dispenser was progressing through their accredited course and the pharmacist providing the vaccination services kept their knowledge up to date by completing regular learning required to provide those services. 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 felt confident in sharing feedback and in raising a concern at work if the need arose. But there was no whistle blowing policy available for them to refer to in the event they needed to escalate a concern. A team member demonstrated how their ideas were used to inform improvements to pharmacy services. For example, the pharmacy had adopted an alphabetised filing system to manage its dispensing workload. This had improved the efficiency in finding prescriptions waiting to be dispensed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and maintained to an appropriate standard. The pharmacy has facilities to allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was secure against unauthorised access, and it was clean. The pharmacy used local tradespeople to manage any maintenance concerns. There were no current maintenance or health and safety concerns. 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 was a suitable size for the level of activity undertaken. But the amount of available workspace was reduced due to paperwork and other items being held on work benches rather than in the storage area. Team members were observed working safely in the space available. The team also used a dedicated area at the back of the dispensary for workload associated with supplying medicines in multi-compartment compliance packs. Some boxes containing out-of-date medicines were held on the floor of the dispensary. These were pushed up against work benches to prevent them being a trip or fall hazard. To the side of the dispensary was a store area and access to staff facilities. Lighting and heating arrangements were appropriate. Sinks were equipped with antibacterial soap and towels.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it stores its medicines safely and securely. Its team members complete regular checks to ensure medicines are safe to supply to people. Pharmacy team members provide people with relevant information when supplying medicines and they keep good records when supplying medicines to vulnerable people.

Inspector's evidence

The pharmacy had step-free access. It was within a pedestrian zone with free parking close by. The pharmacy displayed details of its opening times and the services it provided. Pharmacy team members knew to signpost people to other sources of support should the pharmacy be unable to provide a service or supply a medicine. The pharmacy operated a local booking system to support in managing its flu and COVID-19 vaccination services. The pharmacist providing this service had access to current information such as service level agreements and patient group directions to support them in delivering the service safely. They also accessed the Specialist Pharmacy Service website regularly to keep their knowledge up to date. And they had contacted the local Integrated Care Board's clinical team for support when they had a specific query.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. And pharmacists had good supervision of the medicine counter. Pharmacists regularly counselled people about their medicines and answered any questions they had. Pharmacists recorded some intervention notes on people's medication record (PMR) when providing counselling. This supported the team in providing person-centred care. 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 and this provided an audit trail of the deliveries made. Pharmacy team members had an awareness of the valproate Pregnancy Prevention Programme (PPP). The SI explained the pharmacy did not currently dispense to people in the at-risk group. They had introduced a cautionary information notice informing team members of the PPP requirements, this was displayed next to valproate in the dispensary. The SI discussed the recent legal changes to about the supply of valproate in original packs. And they had subsequently reviewed the supply of valproate to ensure the pharmacy supplied the medicine as the changes required. The pharmacy team checked the prescriptions towards the end of each working day. And 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. There was a particular emphasis on doing this on a Wednesday as the pharmacy closed at 2pm. 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 and referred to this when later supplying the medicine. Pharmacy team members stated they usually signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. But a random sample of assembled items found only the pharmacist had signed the labels to confirm they had completed an accuracy check of the medicine. This could make it more difficult to know who had been involved in the

dispensing process should a query arise. 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. A sample of compliance packs checked 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 its medicines in an orderly manner, in their original packaging. CDs stored securely in cabinets with patient-returned CDs and out-of-date CDs clearly labelled and separated from stock medicines. The pharmacy had two medical fridges for medicines requiring cold storage. The team kept temperature records showing the operating temperature range of the fridges. A sample of these records were checked and showed the fridges were operating within the required temperature range of two and eight degrees Celsius. Pharmacy team members explained they completed date checking tasks, but they did not keep a record of the checks they made. A random check of stock found no out-of-date medicines. Team members routinely checked expiry dates during the dispensing process to further reduce the risk of supplying an out-of-date medicine. The pharmacy had medicine waste sacks, CD denaturing kits and sharps bins available to support the team in managing pharmaceutical waste. Medicine waste was stored appropriately to reduce any risk of it being mixed up with current stock medicines. The pharmacy received drug alerts and recalls by email and it kept a record of what it had done in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

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 on designed shelving within the dispensary, information on bag labels could not be read from the public area. Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. Its blood pressure machine was from a recognised manufacturer. And equipment to support the safe delivery of the vaccination services was readily available in the consultation room. 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.