General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sai Pharmacy, Unit 6, 19 Stable Walk, South East Block, Goodman Fields, London, E1 8EJ

Pharmacy reference: 9011696

Type of pharmacy: Community

Date of inspection: 11/10/2023

Pharmacy context

The pharmacy is next to a surgery in a largely residential area in central London. It provides a variety of services including NHS dispensing services, the New Medicine Service, flu vaccinations, blood pressure checks and blood glucose checks. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. It receives most of its prescriptions electronically.

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 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 not all met	4.3	Standard not met	The pharmacy does not store all its medicines properly or securely. And it cannot sufficiently demonstrate that it keeps its medicines requiring cold storage at the right temperatures.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy does not always store its medicines properly or keep them secure. But the pharmacy otherwise adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. And it largely protects people's personal information.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) and they appeared to have been reviewed at different times. Some looked to have been due for review several years ago. And some did not have the details of when they had been implemented or by who. The trainee pharmacist explained that near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. She said that team members were usually responsible for rectifying their own mistakes. Near misses were recorded and reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He said that these would be recorded, and a root cause analysis would be undertaken. And he would inform the pharmacy's superintendent pharmacist (SI).

Workspace in the dispensary was largely free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And the pharmacist had a clear space for checking medicines. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

A team member said that the pharmacy would open if the pharmacist had not turned up. And she would inform the SI. She knew that she should not undertake any dispensing tasks but thought that medicines on the general sales list could be sold if there was no responsible pharmacist (RP) signed in. Team members knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the RP was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. The private prescription records were largely completed correctly, but the details of the prescriber were not usually recorded. This could make it harder for the pharmacy to find these details if there was a future query. Team members said that they would ensure that all relevant information was included in future. The pharmacist said that people were signposted to their GP or to the NHS 111 system if they needed a supply of a prescription-only medicine in an emergency without a prescription. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The

recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was shredded in the pharmacy, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. There were some items with patient information kept in the consultation rooms. The pharmacist said that this would be kept secured in the room in future. There were lockable cabinets available to use.

The pharmacist said that he was not aware of any recent complaints. He would try to deal with any in the pharmacy and pass them to the SI if needed. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist was not aware of any recent complaints.

Team members said that there had not been any safeguarding concerns at the pharmacy. Team members had completed training about protecting vulnerable people. And the pharmacy had contact details available for agencies who dealt with safeguarding concerns. One of the team described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. A team member was not sure if the delivery driver had undertaken any safeguarding training. She said that she would check with the regular pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members can raise any concerns, make suggestions, and make professional decisions to ensure people taking medicines are safe. The pharmacy has enough team members to provide its services safely. But it could do more to ensure that team members are enrolled on accredited pharmacy courses in a timely manner.

Inspector's evidence

There was one locum pharmacist, one trainee pharmacist, three trained dispensers and two trainee medicines counter assistants (MCAs) working during the inspection. One of the trainee MCAs had worked at the pharmacy for a little over three months and the SI confirmed that he was in the process of enrolling them on an accredited course. Following the inspection, the SI confirmed that both trainee MCAs had been enrolled on a suitable course. Team members communicated effectively with each other during the inspection to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing and checking tasks.

The trainee MCAs appeared confident when speaking with people. One, when asked was aware of the restrictions on sales of medicines containing pseudoephedrine. And she knew to refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members asked relevant questions to establish whether the medicines were suitable for the person they were intended for.

The trainee pharmacist said that she undertook most of her studying in her own time, but she felt supported by her designated supervisor. And she said that he asked her to shadow him when he undertook some of the more clinical services. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He said that he had recently completed some training to enable him to sell over-the-counter sildenafil, contraceptives, and fexofenadine. One of the dispensers said that team members were not provided with ongoing training on a regular basis, but they did receive some. And some team members had recently completed vaccination training. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to make professional decisions.

Team members said that the SI regularly visited the pharmacy which allowed them to discuss any concerns or issues with him face to face. And they felt that they could discuss any issues with the pharmacist as they arose. Team members said that they had yearly performance reviews with the SI. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout and this presented a professional image. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating available throughout the shop area for people to use while waiting. The pharmacy had two consultation rooms available. They were accessible to wheelchair users, suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

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

Summary findings

The pharmacy does not always store its medicines appropriately. It cannot sufficiently demonstrate that it keeps its medicines requiring cold storage at the appropriate temperatures. And it does not always store its medicines properly or securely. But otherwise, the pharmacy generally provides its services safely and manages them well. It gets its medicines from reputable suppliers. People with a range of needs can access the pharmacy's services. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And he explained that the surgery would put a note on the prescription if the person was due for a blood test and this information was passed on to the patient. He said that most prescriptions were dispensed and checked when the person presented to collect their medicines. This meant that there was the opportunity for the pharmacist to speak with people when the medicines were handed out. The pharmacist said that he checked CDs with people when handing them out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). People would be referred to their GP if they needed to be on the PPP and weren't on one. The pharmacist said that the pharmacy only dispensed whole packs of these medicines and people were provided with the relevant information to help them take their medicines safely.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. A team member said that the regular pharmacist printed copies of any drug alerts and recalls the pharmacy received. But the pharmacist was not working on the day of the inspection, so the team were not sure if any had been received recently. A team member explained how the pharmacy had actioned previous drug alerts and recalls. She said that a record was kept for future reference, but she could not locate the folder during the inspection. She said that she would ensure that other team members knew how to access them in future so that they could be actioned promptly.

Pharmacy-only medicines were largely kept behind the counter but some to the side of the counter and were accessible to people using the pharmacy. And a few pharmacy-only medicines and a prescription-only medicine (POM) were found in the shop area during a spot check. A team member moved these medicines during the inspection and reminded team members to check medicines before putting them out on the shop floor. Additionally, some prescription-only medicines and dispensed medicines were stored in an area which was potentially accessible to people using the pharmacy. The SI confirmed that access to this area would be restricted.

The pharmacy had two dispensing robots. The trainee pharmacist said that the robot in the main dispensary area was waiting to be fixed. It could be accessed manually if stock was needed, but most of

the pharmacy stock was not kept in the robot now. Stock was largely stored in an organised manner in the dispensary. A team member said that expiry dates were checked regularly but this activity was not recorded. This could make it harder for the team to know which sections had been checked. Some short-dated items were highlighted but there were several boxes which contained mixed batches found with dispensing stock. And one box of levofloxacin contained an itraconazole capsule. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. Team members said that they would ensure that medicines were kept in their original packaging in future.

Team members said that there had not been any CDs returned by people since the pharmacy opened. The trainee pharmacist said that these would be recorded on the computer and destroyed with a witness. Some CDs requiring safe storage were not stored in accordance with legal requirements. The pharmacist put these CDs in the cabinet during the inspection and provided assurances that these would be kept in there until a suitable cabinet was installed. Following the inspection, the SI confirmed that a suitable CD cabinet had been ordered and would be used to store these medicines once installed.

The pharmacy had two fridges for storing medicines which require cold storage. The current temperature for both fridges was within the appropriate range on the day of the inspection. But there was an alarm showing on the large fridge and team members did not know what this was for. A team member said that they would contact the fridge manufacturer to ask about this. The pharmacist said that he checked the current fridge temperatures daily, but these were not usually recorded. There had been a few entries made recently but nothing before these. And the temperatures entered on the record did not match those showing on the thermometers. The maximum and minimum temperatures for both fridges were outside the appropriate range. The thermometers were reset during the inspection and the temperatures remained within range for the remainder of the inspection. Team members said that they would ensure that the maximum and minimum temperatures were checked and recorded daily.

There were very few prescriptions waiting collection. The pharmacist explained that people usually contacted the pharmacy after they had been issued a prescription to request that it be dispensed. The pharmacy would then prepare it ready to be collected. The pharmacist said that people usually had to wait around five to ten minutes for their prescription to be dispensed if they had not contacted the pharmacy beforehand. Part-dispensed prescriptions were checked daily. ‘Owings’ notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

People had assessments with their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for ‘when required’ medicines were requested if people needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. A picture of the medications and descriptions were put on the packs to help people and their carers identify the medicines. And patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. A second dispensing robot was used to assemble the packs. Team members said that this had reduced the number of mistakes and it had also made the workload easier to manage. There were two dispensers responsible for assembling the packs. They had received training on how to use the robot and said that the robot engineers could remotely access the system if there was a fault. And an engineer would attend the pharmacy the following day if the issue could not be fixed remotely. The team worked around four days ahead so that

any issues with the robot could be dealt with before people needed their medicines.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around two months and would be replaced in line with the manufacturer's guidance. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. One of the dispensers said that they would order a suitable measure. Separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Team members sometimes used an electronic device to counter tablets and capsules. There was a thick layer of powder residue throughout the machine and a team member said that it sometimes did not always accurately count them. The inspector discussed this with one of the team during the inspection and she said that she would ensure that the counter was kept clean in future.

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.