General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Abrar Rehman Pharmacy, Ashwell Medical Centre, Ashwell Road, Manningham, Bradford, West Yorkshire, BD8 9DP

Pharmacy reference: 9011774

Type of pharmacy: Community

Date of inspection: 19/10/2023

Pharmacy context

The pharmacy is in a health centre in the suburbs of Bradford city centre. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They supply some medicines for people in multi-compartment compliance packs. And they provide seasonal flu and Covid-19 vaccinations to people. The pharmacy delivers medicines to people's homes.

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 adequately keep or manage the records it needs to help provide its services safely and effectively. This includes records of controlled drugs, records associated with services, and to help achieve proper medicines management.
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 effectively manage or store some of its medicines safely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy keeps the records it needs to by law. But it does not keep and maintain some of its records to help it provide services safely and effectively. It adequately identifies and manages other risks associated with its services. And it has documented procedures to help team members achieve this. Pharmacy team members understand their role in helping to protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. But they do not regularly analyse errors for patterns and trends. So, they may miss additional opportunities to learn and make effective changes to help make services safer.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks to its services. Pharmacy team members accessed the SOPs electronically. The pharmacy owner had reviewed the sample of SOPs seen in 2022, and these were due to be reviewed again in 2024. Pharmacy team members confirmed they had read the current procedures. But there were no records available to confirm that team members had read and understood the procedures.

The pharmacy provided a popular seasonal vaccination service to people. The service included vaccinations for flu and for the Covid-19 booster vaccination programme. The pharmacy had considered some of the risks of delivering vaccinations to people. The responsible pharmacist (RP) explained how they assessed various risks, such as the suitability of the pharmacy's consultation room and the availability of the necessary equipment. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis. Vaccinations were provided to people by the pharmacist, a trainee pharmacist and a trainee pharmacy technician. The pharmacy had a patient group directive (PGD) and an NHS national protocol available, which enabled team members to provide vaccinations to people. But team members were not always sure which legal mechanism related to their role. A team member clearly explained the process they followed when they delivered a vaccination. This included asking people clinical screening questions. They showed the pharmacist the completed screening questionnaire, who then determined if it was appropriate to vaccinate someone or not.

Pharmacy team members highlighted and recorded near miss and dispensing errors. There were documented procedures to help team members do this effectively. They discussed any errors and why they might have happened, and they recorded some information about each error. Pharmacy team members did not record any information about why the mistakes had been made or the changes they had made to prevent a recurrence to help aid future learning. But they gave examples of separating different strengths of medicines to help prevent picking errors, and clearly marking split packs to help prevent quantity errors in response to mistakes they had made. The pharmacy manager, who was also a dispenser, explained that they looked at the data collected about near miss errors to establish any patterns. But they did not do this regularly or record their findings. This was discussed and they gave their assurance that they would record more regular analyses to help inform the changes they made in response to errors.

The pharmacy had a documented procedure to deal with complaints handling and reporting. It

collected feedback from people verbally. And there was a poster available for people in the retail area which gave instructions about how to make a complaint. The pharmacy did not have any records of any feedback or complaints they had received.

The pharmacy's-controlled drug (CD) registers were kept electronically and were complete. It kept running balances in all registers. These were audited against the physical stock quantity approximately weekly. But pharmacy team members did not effectively manage some running balances, and inaccuracies were identified. And there were several CDs in the CD cabinet that had been returned by people for destruction that had not been recorded in the returns register. The pharmacy had up-to-date professional indemnity insurance in place. It maintained a responsible pharmacist record electronically, which was complete and up to date. The pharmacy kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. Pharmacy team members collected confidential waste in dedicated bags, which were sealed when full and collected for secure destruction. They explained how they protected people's privacy and confidential information. And the pharmacy had a documented procedure about confidentiality and data protection available to help the team achieve this. Pharmacy team members gave some examples of signs that would raise their concerns about vulnerable children and adults. They explained how they would refer their concerns to the pharmacist and would use the internet to find contact details for local safeguarding teams to report their concerns to. The RP had completed training on safeguarding in 2022. Other pharmacy team members had not completed any formal safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide or are enrolled on appropriate training courses. They complete some additional training to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they sometimes make changes to improve the way they manage their services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist who worked at the pharmacy regularly, a trainee pharmacist, three dispensers, one of whom was the pharmacy manager, two trainee dispensers, and a trainee medicines counter assistant. Team members had the right qualifications for their roles or were enrolled on appropriate training courses. And they managed the workload well during the inspection. Pharmacy team members completed additional training ad hoc by reading various pharmacy-related articles and discussing topics suggested by the pharmacist and pharmacy manager. But they could not give any examples of any training that they had completed recently. Team members received an informal appraisal every two to three months, where they discussed their progress. They explained they would raise any learning needs informally with the pharmacist or manager, who would teach them or signpost them to appropriate resources.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. Following a discussion where team members had identified areas for improvement, the pharmacy had changed the way they managed invoices they received for CDs. This was to help make sure that CDs were correctly entered into the CD registers. Pharmacy team members explained they would raise professional concerns with the pharmacist, manager or area manager. They felt comfortable raising concerns. And confident that concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy, and instructions about how to access the procedure was displayed to team members in the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. And it has a consultation room where people can speak to pharmacy team members privately. It generally provides a suitable space for the services it provides.

Inspector's evidence

The pharmacy was clean and well maintained. The area used for preparing prescriptions was small, and there was a limited amount of bench space for the volume of dispensing being undertaken. But pharmacy team members generally kept these benches organised to help maximise the space they had available. The pharmacy had a defined area which team members used to prepare and check multi-compartment compliance packs. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. But some areas of the pharmacy were less well organised which impacted on the space available.

The pharmacy had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people and to provide some services from. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet elsewhere in the health centre the building, with a sink with hot and cold running water and other hand washing facilities. The pharmacy kept its heating and lighting to acceptable levels. And its overall appearance was professional.

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

Summary findings

The pharmacy does not always store and manage its medicines appropriately. This means it may not be able to adequately ensure the safety of its medicines. And it could increase the risks of team members making mistakes when dispensing prescriptions. The pharmacy's services are easy for people to access. And it has processes in place to help people understand the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the car park, via the health centre's reception area and via a separate pharmacy entrance. It also had an automatic door to help people gain access to the pharmacy. Pharmacy team members explained how they would support people who may have difficulty accessing the pharmacy's services. They explained how they would communicate in writing or use hand signals and visual aids to communicate with people with a hearing impairment. But they were unsure about how to help people with a visual impairment. Pharmacy team members were also able to speak several languages spoken locally, including Urdu and Punjabi as well as English. They explained they had also used an online translation tool to help communicate with people who spoke other European languages, such as Polish.

Several areas of the pharmacy's shelves where medicines were stored were overfull, cluttered, and untidy. This was particularly seen in the area where the pharmacy stored their "fast-movers" which were the medicines they dispensed most often. The medicines stored on these shelves were disorganised and there were several examples of look-alike and sound-alike medicines and different strengths of the same medicine being stored together in the same stack of boxes, which increased the risk of team members selecting the wrong medicine or strength when dispensing. In addition, several amber bottles and medicines cartons were found on the shelves in the dispensary containing medicines that had been removed from their original packaging. Some of these bottles had labels attached giving information about the medicine and its strength. But none of the labels showed a batch number or expiry date of the medicines in the bottles. And some bottles and containers did not have any labels attached, so team members could not properly identify the medicines. And team members had not considered the stability of medicines once removed from their original packaging, to determine whether they were safe to use. Several boxes were found on the pharmacy's shelves that contained mixed batches of medicines. One unlabelled box contained several foil strips of tablets that had been cut during dispensing. Some of the strips could be identified as perindopril 8mg tablets. But other strips did not have any identifying information, and most of the strips also did not display a batch number or expiry date. This increased the risk that these medicines would be dispensed incorrectly. Or would not be identified and removed in the event of a manufacturers recall or if the medicines had expired.

The pharmacy had a documented procedure for checking stock for short-dated and expired medicines. But this did not match the process being carried out by pharmacy team members. The pharmacy did not have any records available of any expiry date checking being completed. A dispenser explained that team members completed date checking every month. Pharmacy team members highlighted medicines that were due to expire by attaching a sticker to the pack if the medicine was due to expire within three months, and they removed expiring items during their month of expiry. No out-of-date medicines were found on the shelves.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And they checked if the person was aware of the risks if they became pregnant while taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had printed materials available to provide to people to help them manage the risks of taking valproate. But the pharmacy had not completed any audits to establish whether advice had been provided to everyone who it provided with valproate. Team members were aware of recent changes that required valproate to be dispensed in the manufacturer's original packs.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members did not always include descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. But they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the person's electronic patient medication record (PMR).

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people. It recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The delivery driver then automatically tried to deliver again the following day, before returning the medicines to the pharmacy once more and highlighting the failed delivery to the pharmacy manager. The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. The pharmacy stored controlled drugs (CDs) in a locked CD cabinet. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mostly has the necessary equipment available, which it properly maintains. And the team manages and uses the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. It kept its computer terminals in the secure areas of the pharmacy, away from public view, and these were password protected. And bags of medicines waiting to be collected were kept in the secure areas of the pharmacy, away from public view, so people's private information was protected. The pharmacy restricted access to its equipment. It had a set of clean, well-maintained measures available for medicines preparation. It had a separate set of measures exclusively to prepare methadone.

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.