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: 09/05/2024

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 the NHS New Medicines Service and Blood Pressure Check service for 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 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 manage or store some of its medicines safely, including effectively checking medicines' expiry dates. This was highlighted at the pharmacy's last inspection and the agreed improvements have not been maintained.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages risks with providing its services. It has written procedures relevant to its services to help team members provide them safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. They record and discuss the mistakes they make so that they can learn from them. But they don't always capture key information or analyse their mistakes for patterns, so they may miss some opportunities to learn and improve.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) in place to help pharmacy team members manage the risks to most of 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. And some pharmacy team members had signed to confirm they had read and understood them. When the inspector arrived at the pharmacy, there was no pharmacist present. Team members explained the pharmacist had been unexpectedly delayed and had not yet arrived for the day. Team members were not seen handing out any prescriptions or selling any medicines to people. But they were preparing prescriptions ready for the pharmacist to check. Team members were unclear about the activities they could and could not carry out in the responsible pharmacist's (RPs) absence. But they were clear that they could not sell any medicines or hand out completed prescriptions. Team members could not find an SOP to help them manage the pharmacy's services if the pharmacist did not arrive and assume responsibility for the pharmacy's operation.

The pharmacy provided the NHS New Medicines Service for people. Pharmacy team members had considered some of the risks of delivering the service to people, such as the suitability of the pharmacy's consultation room. But these assessments had not been written down to help team members manage emerging risks on an ongoing basis. The pharmacy had an SOP and service specification available electronically to help team members manage the service. The pharmacist provided people with the initial consultation about their new medicines. They recorded their consultations and any advice they had given. The pharmacist also conducted the necessary follow-up consultations with people. And sometimes the trainee pharmacists were involved with these follow-up consultations to help with their professional training, under the pharmacist's direct supervision. The trainee pharmacist was confident about conducting these consultations and provided clear examples of some circumstances where they would refer to the pharmacist for advice. The pharmacy also provided the NHS Blood Pressure Check service for people. And the pharmacy had assessed the risks of providing the service in a similar way. The pharmacist had trained several pharmacy team members to provide the service, including dispensers and a medicines counter assistant. Team members had read the SOP for the service, and they had been trained about hypertension and how to use the blood pressure monitor by the pharmacist. But the pharmacy did not keep any records of the training it had provided team members with, to help monitor ongoing learning and development.

Pharmacy team members highlighted and recorded mistakes that were identified before people received their medicines, known as near misses. And mistakes identified after people had received their medicines, known as dispensing errors. There were documented procedures to help team members do this effectively. They discussed any mistakes and why they might have happened, and they recorded

some information about each mistake. 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 look-alike and sound alike medicines nortriptyline and nitrofurantoin, to help prevent picking errors. The pharmacy manager, who was also a dispenser, explained that they looked at the data collected about near miss errors to establish any patterns approximately every two to three months. But they did not record their findings to help aid future refection.

The pharmacy had a documented procedure to deal with complaints handling and reporting. Team members 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 had current professional indemnity insurance. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. It maintained a responsible pharmacist record, which was also up to date and completed accurately. The pharmacist displayed their responsible pharmacist notice so they could be identified. Pharmacy team members monitored and recorded fridge temperatures daily. And they accurately recorded private prescriptions and emergency supplies.

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 completed formal safeguarding training in 2024.

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, five dispensers, one of whom was the pharmacy manager, and a medicines counter assistant. Team members had the right qualifications for their roles. 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. Some recent topics included safeguarding and antimicrobial stewardship. 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. This was further limited because several areas of bench space were cluttered with dispensing baskets containing medicines at different stages of the dispensing process. This was discussed and the manager explained the pharmacy were currently working to reduce their stock holding to help create more shelf space to use as storage. The pharmacy had a defined area which team members used to prepare and check multi-compartment compliance packs which was tidy and well organised. The pharmacy’s floors and passageways were generally free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises.

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 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 people receiving medicines that are out of date. 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 languages, such as Polish.

Several boxes were found on the pharmacy's shelves that contained mixed batches of medicines. One example was a box of mycophenolate 250mg tablets. The box showed an expiry date of February 2025, but there were strips of medicines in the box with shorter expiry dates. Some of the strips had an expiry date of August 2024, and some had expired, showing an expiry of April 2024. Several other boxes contained strips that 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 regular expiry date checking being completed. The only record available was a list of medicines that had been removed and destroyed in December 2023. 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. After a check of the shelves, three medicines were found that were out of date, all of which had expired in April 2024.

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 included descriptions on the backing sheets of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines at least 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 preparing liquid medicines. 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.