General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: N K Jank Chemist, 32a Eltisley Avenue, Newnham, CAMBRIDGE, Cambridgeshire, CB3 9JG

Pharmacy reference: 1029213

Type of pharmacy: Community

Date of inspection: 20/02/2024

Pharmacy context

This pharmacy is located in a residential area of Newnham, Cambridge. It dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them take their medicines at the right time. The pharmacy provides some limited NHS services such as the New Medicine Service and the Discharge Medicine Service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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

The pharmacy identifies and manages risks to help make sure that the services it provides are safe for people to use. Team members follow written procedures so that they can carry out tasks safely and they have some opportunities to learn from mistakes that may occur. The pharmacy generally keeps the records that are needed by law and protects people's private information. The pharmacy can receive feedback and complaints and team members also look after the wellbeing of those people who may be vulnerable.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that were currently being reviewed by the superintendent pharmacist (SI). Its team members explained they had read the SOPs but had not signed the training record to show this. They were aware of their roles and responsibilities according to the procedures in place and they were seen following the written processes that had been adopted. Team members had signed a confidentiality agreement and understood how to protect people's data. Patient medication records (PMRs) were password protected and confidential information was stored securely from unauthorised access. There was a system to separate confidential waste from general waste and the team used a shredder to destroy any confidential material. Members of the team completed annual refresher training on confidentiality and protecting data when completing the NHS Data and Security Protection toolkit. The pharmacy had professional indemnity insurance which covered the services that it offered.

There was a process to identify and record mistakes that were made and corrected during the dispensing process, also known as near misses. The pharmacist would highlight the mistake to the team member involved and they would make a record in a near miss log. The SI admitted that these types of mistakes were not recorded as often as they should be. This meant that members of the team could not review the near misses and identify any common trends to act upon. The SI provided an assurance that they discussed mistakes as they happened but would make a record going forwards so that a regular review could be completed. Team members provided some examples of medicines being moved and separated in the dispensary to avoid picking errors being repeated. These examples included the physical separation of enalapril and escitalopram and keeping warfarin products on a separate shelf. They explained that any mistakes that were identified after medicines were supplied to people, also known as dispensing errors, were referred to the SI. The SI would investigate the error and any learning points would be shared.

The responsible pharmacist (RP) record was kept electronically. A few entries were missing both the sign in and sign out times of the RP which may make it harder to identify if one was present. Some entries were also missing a sign out time which may make it difficult to identify when their responsibility had ended. The SI provided an assurance that they would ask all locum pharmacists to complete the RP record in full. The pharmacy occasionally supplied unlicensed medicines to people and a complete record was kept. It also supplied some medicines that were prescribed on private prescription forms. These were recorded on an electronic private prescription register and the records were generally in order. But the name of the prescriber was often incorrect or missing altogether, which could cause confusion in the event of a query. Records for controlled drugs (CDs) were in order. Running balances were recorded. Running balances for four CDs were checked and found to match the

physical quantities that were being held in the cabinet. CDs that were returned to the pharmacy were recorded in a separate register and the entries were signed when destroyed.

Members of the pharmacy team were aware of the safeguarding procedure and what to do if they had any concerns to support the wellbeing of anyone vulnerable. When questioned, one of the dispensing assistants was able to describe the signs that would indicate a potential safeguarding issue. In such cases, they would refer to the RP. Details of the local safeguarding contacts were easily accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to effectively manage the workload. And they feel comfortable about raising any concerns and making suggestions to improve the way they work.

Inspector's evidence

The pharmacy team comprised of the SI, a locum pharmacist and two part-time dispensing assistants. The SI did not regularly work at the pharmacy but oversaw the operations of the pharmacy and management of its team members. The pharmacy used a small selection of locum pharmacists to take on the daily responsibilities. Members of the team were qualified for the roles they fulfilled. There was no structured ongoing training which may mean the team members find it harder to keep their skills and knowledge up to date. The SI explained they shared any information about new processes or guidance with the team verbally.

Annual appraisals were not held with team members but, when questioned, one of the dispensers felt comfortable providing feedback or raising a concern to the SI. The pharmacy team members started each day with a brief conversation to help them prioritise and manage the workload effectively. And they were seen working well together to serve people who entered the pharmacy to collect their medicines. The pharmacy team had a process to cover for holidays and periods of absence to make sure the level of service it provided remained consistent.

One of the dispensing assistants was aware of the process to follow if they had multiple requests from the same person for medicines that were liable to abuse. And they knew the correct questions to ask when selling medicines over the counter. Team members had adequate signposting information available in the form of leaflets to help them with their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally clean and tidy, but some areas are cluttered which detracts from the image presented. The pharmacy's consultation room is not readily usable which may make it harder for people to have a private conversation about their health. The premises are otherwise generally suitable for the pharmacy's services, and they are secure from unauthorised access when the pharmacy is closed.

Inspector's evidence

The pharmacy was generally clean and organised, but some areas of the dispensary were cluttered mainly due to its small size which meant that it looked untidy. However, members of the team had clear bench space to work on which helped to make sure prescriptions were assembled in a safe and effective manner. The pharmacy had adequate lighting and the temperature was maintained to a suitable level. Any maintenance issues were reported to the SI who contacted local contractors for repairs. The premises was secured when closed.

The pharmacy had a consultation room situated at the back of the dispensary. But due to the lack of space, the room was being used for additional storage. Some medicines awaiting collection were also stored in the room. The SI explained that the pharmacy provided a very limited number of services and if the consultation room was needed for people to have a private conversation with a team member or to receive a service then steps were taken to protect people's private information. For example, members of the team would accompany people through the dispensary to the consultation room and a roller blind was used to cover any medicines awaiting collection, so people's names and addresses were hidden. When questioned, the pharmacist explained they used a quiet area of the pharmacy retail area to have a private conversation so not to be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. And its team members provide additional advice to people taking higher-risk medicines.

Inspector's evidence

The pharmacy was easily accessible and had an internal ramp that led into the retail area making it suitable for those with a wheelchair or pushchair. The opening hours of the pharmacy were clearly displayed.

The pharmacy team members were observed dispensing and checking prescriptions in line with the SOPs that were in place. They used baskets to separate each person's prescription to prevent the transfer of different people's medicines. A record was kept by signing the 'dispensed by' and 'checked by' boxes on the dispensing label to recognise who was involved in the dispensing process.

The team members used a range of stickers to mark any prescriptions that would need pharmacist intervention when they were handed out. This included prescriptions for high-risk medicines such as sodium valproate so people could be counselled. The pharmacist was aware of the additional counselling about pregnancy prevention required with sodium valproate products and the steps to take with people in the at risk-group. This also included providing valproate-containing medicines in their original container so that the patient warning card and patient information leaflet were provided with each supply. Prescriptions for Schedule 2, 3, and 4 CDs were highlighted to help the pharmacy team members make sure they were not handed out beyond the prescription's legal validity. And team members also highlighted prescriptions with a sticker when a fridge item needed to be added before being supplied to people.

The pharmacy supplied medicines in multi-compartment compliance packs to a few people in the local area who required additional support to manage their medicines better. The two dispensing assistants shared the responsibility of assembling the packs so that there was continuity if one of them was absent or on leave. Compliance packs were assembled and supplied in advance of when they were needed and organised on a weekly basis to make sure enough time was available to make the packs safely. Each person who received a compliance pack had a record of their medication, and any notes such as changes or hospital discharge letters. Compliance packs contained descriptions of the individual medicines that were being supplied to make it easier for people to identify them. The team also supplied patient information leaflets so that people had access to additional information about their medicines.

Medicines were obtained from a range of licenced wholesalers and stored appropriately as required to maintain their integrity. Medicines were stored in their original packs and in an organised manner. Medicines that required cold chain storage were stored in a suitable medical grade fridge. The pharmacy team checked and recorded fridge temperatures daily and these were found to be in the required range. CDs were stored securely in a suitable cabinet. CD stock that had expired or had been returned to the pharmacy was clearly marked and separated from stock available for dispensing. The pharmacy team said they checked the expiry dates of medicines on a regular basis, but no records had

been made. This may make it harder to establish which sections of the pharmacy had been checked and by who if any expired stock was found. A process was in place to highlight short-dated stock with a round sticker. And team members recorded short-dated medicines in a diary under the month they were due to expire. They would then remove these from the shelf at the beginning of the relevant month if they had not been supplied. A selection of medicines stored on the shelves was checked, and none were found to be out of date.

The pharmacy received drug alerts and safety recalls by email. Its team members checked the pharmacy for any affected stock but did not make a record of the actions taken. This may make it harder for them to respond to any queries following a safety alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the necessary equipment that it needs to provide its services. And it uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy had equipment in working order to help it provide the services that it offered. Calibrated and clean conical measures were available to measure liquid medicines. Counting triangles were available and a separate one was labelled for any medicines that were cytotoxic to prevent cross contamination. The pharmacist accessed an electronic copy of the BNF and the electronic medicines compendium when needed. There were some health information leaflets available for people to read.

The pharmacy used cordless phones to keep telephone conversations private from people entering the pharmacy. And computer screens were positioned in a way to protect people’s information.

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.