General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rishi Pharmacy Limited, 84 Hart Road, Thundersley, BENFLEET, Essex, SS7 3PF

Pharmacy reference: 1030980

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area near to a seaside town. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including dispensing and over-the-counter sales. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

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 not all met	2.2	Standard not met	The pharmacy does not always ensure that team members are undergoing training appropriate for their role. And this means that they may not have the skills or knowledge they need to provide the pharmacy's services safely.
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 adequately identifies and manages the risks associated with its services to help provide them safely. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information. People who use the pharmacy can provide feedback about its services. And team members understand their role in protecting vulnerable people. But the pharmacy doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. There were documented up-to-date standard operating procedures (SOPs) available. But team members had not signed to show that they had read, understood and agreed to follow the SOPs. The trainee medicines counter assistant (MCA) said that she had not read the SOPs and she had worked at the pharmacy for around four years. The responsible pharmacist (RP) SOP 'roles and what to do in the absence of the RP' gave conflicting information about what team members could and couldn't do if the pharmacist had not turned up. The superintendent (SI) pharmacist said that he had been in contact with the Local Pharmaceutical Committee and planned to review the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses had previously been recorded, but the log had not been in use for around one-year. The SI said that there had been several near misses over the last year and he would ensure that any were recorded in the future. And he would review the near miss log for patterns. He said that he was not aware of any recent dispensing incidents where the wrong product had been supplied to a person. He said that he would record any incidents on the pharmacy's computer and this would be linked to the person's medication record.

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

The trainee medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up in the morning. She knew that she could accept prescriptions and that she should not hand out any dispensed items until the pharmacist had signed in. But she thought that she could sell general sales list medicines if there was no RP. The inspector reminded her what she could and couldn't do if there was no RP. The trainee dispenser knew that he should not carry out any dispensing tasks if there was no RP.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. The RP record was completed correctly, but the responsible pharmacist (RP) notice was not clearly displayed at the start of the inspection. It was obscured with some items, but the trainee MCA moved these when prompted.

Controlled drug (CD) registers examined were largely filled in correctly. But the address of the supplier

was not routinely recorded. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded correctly or they were missing. And the date on the prescription was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The SI said that he would ensure that the private prescription record and emergency supply record were completed correctly in the future.

Confidential waste was shredded, 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.

The SI said that the pharmacy did not carry out patient satisfaction surveys. The complaints procedure was available for team members to follow if needed. The trainee MCA said that she would refer any complaints to the pharmacist on duty. The SI said that there had not been any recent complaints.

The SI had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members said that they had not undertaken any safeguarding training. The trainee MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The SI said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always ensure that relevant team members are enrolled on accredited pharmacy courses within the required timeframe. And team members do not always get ongoing training. This could mean that they do not have all the required skills and knowledge they need to undertake their tasks safely. However, the pharmacy has enough team members to provide its services safely. The team members can take professional decisions to ensure people taking medicines are safe. And team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

The SI was working in the day of the inspection, alongside a trainee dispenser and a trainee MCA. The trainee dispenser said that he had been enrolled on an accredited dispenser course. But his last day working at the pharmacy was the day of the inspection. The trainee MCA said that she had worked at the pharmacy for around four years. She said that she had not been enrolled on an accredited course for her role, but the SI thought that she had. The SI said that he would ensure that the trainee MCA and the person who worked on Saturday's were enrolled on accredited courses. The SI said that he was in the process of recruiting a dispenser or a trainee dispenser. The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She was not aware of the restrictions on sales of pseudoephedrine containing products. She said that she would refer to the pharmacist if a person asked to buy more than one box of any over-the-counter medicine. Or if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether the medicines were suitable for the person. She said that she did not receive any ongoing training for her role.

The SI was aware of the continuing professional development requirement for the professional revalidation process. He said that he read pharmacy related magazines to keep his knowledge up to date. And he felt able to take professional decisions. The trainee dispenser said that he had worked at the pharmacy for around seven years, but he had not undergone any performance review or appraisal. He said that he felt able to provide feedback to the SI about any pharmacy related issues. The trainee MCA said that the pharmacy did not hold regular meetings and information was usually passed on informally. 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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. 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; the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned near to the medicines counter so conversations at the counter may be overheard. The SI said that he would allow a person access to the dispensary if they asked to speak with him in a more private setting. He said that he would ensure that the person was not left alone and that there was no confidential information visible.

The pharmacy did not currently have a consultation room. The SI said that he had spoken with a representative from the NHS and it had been agreed that a consultation room could be built in a storage unit to the rear of the pharmacy. Access to the unit was via a side entrance to the courtyard. The storage area to was kept locked when not in use as the courtyard was used to access the flat above the pharmacy. Toilet and hand washing facilities were located in a room in the courtyard. They were clean and not used for storing pharmacy items.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and largely stores them properly. People with a range of needs can access the pharmacy's services. And the pharmacy responds to drug alerts and product recalls. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was one step up to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and dispensary 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 SI said that he checked that people taking higher-risk medicines such as methotrexate and warfarin were having regular blood tests. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 CDs were highlighted, but prescriptions for Schedule 4 CDs weren't. This could increase the chance of these medicines being supplied when the prescription was no longer valid. The SI said that he would highlight prescriptions for higher-risk medicines and Schedule 4 CDs in the future. He said that 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. The pharmacy had not yet received the updated version of the relevant patient information leaflets or warning cards. The SI said that he would request these from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. There were several boxes which contained mixed batches found with dispensing stock. 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. The SI said that he would ensure that medicines were kept in their original packaging in the future.

Part-dispensed prescriptions were checked frequently. '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. The SI said that uncollected prescriptions were checked regularly. And any uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The SI said that people who had their medicines in multi-compartment compliance packs had assessments with their GPs to show that they needed the packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the

SI said that people requested prescriptions for these items if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines. But the patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The SI said that he would ensure that the patient information leaflets were supplied in the future.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. 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. The SI said that the delivery service was usually offered to those people who could not access the pharmacy themselves.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not appear to have any record of action taken since 2017. The recent emails had been opened and the SI said that he would ensure that any action taken was recorded and kept for future reference. This would make it easier for the pharmacy to show what it had done in response. The pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. The SI said that he would contact the software provider and order the equipment.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; 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.

Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order and the phone in the dispensary was portable, so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.