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: 08/04/2021

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. It provides a range of services, including dispensing and over-the-counter sales. And 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 met**

Required Action: None

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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

Overall, the pharmacy 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 properly. People who use the pharmacy can provide feedback about its services. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. These included documented reporting and reviewing of dispensing mistakes. Workplace risk assessments in relation to Covid-19 had been carried out. And documented up-to-date standard operating procedures (SOPs) were available. The superintendent (SI) pharmacist said that he had been in contact with the Local Pharmaceutical Committee and the SOPs had been reviewed recently. He was in the process of printing them so that team members could read and sign to show that they had understood the SOPs. 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. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The SI was not aware of any recent dispensing errors, where a dispensing mistake had reached a person. He said that he would record any such errors 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 dispenser said that the pharmacy would not 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. And she was aware what tasks should not be undertaken if the pharmacist was signed in as the responsible pharmacist (RP), but not physically present in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The RP record was completed correctly and the right RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were largely filled in correctly. But the address of the supplier was not routinely recorded. The SI said that he would ensure that all the required information was recorded in future. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. CD running balances were checked at regular intervals. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded correctly or they were missing. This could make it harder for the pharmacy to find these details if there was a future query.

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 had not carried out a patient satisfaction survey within the last year. Questionnaires were available in the pharmacy and the complaints procedure was available for team members to follow if needed. The trainee dispenser 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 had undertaken some safeguarding training provided by the pharmacy. The trainee dispenser 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 met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they had been provided with some ongoing training prior to the pandemic, but work pressures meant that this had been temporarily put on hold. They can raise any concerns or make suggestions and team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

The SI was working on the day of the inspection, alongside a trained dispenser and a trainee dispenser. Team members worked well together and communicated effectively during the inspection to ensure that tasks were prioritised and the workload was well managed. The trainee dispenser confirmed that she had been enrolled on an accredited dispenser course since the last inspection. But she had not had much time to complete any of the modules due to the work pressures during the pandemic. The SI explained that team members were starting to have allocated training time each week and appraisals and performance reviews would be carried out in the future. But at the moment, information was passed on informally during the working day. The trainee dispenser said that she felt able to provide feedback to the SI about any pharmacy related issues. The SI said that the pharmacy tried to have quarterly meetings.

The trainee dispenser appeared confident when speaking with people. She was 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 pharmacy-only 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.

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. He had recently completed some training about the Community Pharmacist Consultation Service provided by the Local Pharmaceutical Committee (LPC). He felt able to take professional decisions and service-related 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 was no screen at the medicines counter, but it was deep, and people were at a suitable distance from team members at the counter. The pharmacy only allowed three people in the shop area at a time.

There were two chairs in the shop area. The was sufficient space between them to allow people using them to keep a suitable distance from each other. The pharmacy did not currently have a consultation room, but the pharmacy was in the process of having one installed in the shop area. The SI said that he would allow a person access to the front area of 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 storage area to the rear of the pharmacy 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 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 so that people get medicines and medical devices that are safe to use. But the pharmacy doesn't always keep prescriptions with dispensed medicines until they are supplied. And this could make it harder for team members to refer to the original prescription if there was a query.

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. And a record of blood test results was kept. The SI explained that prescriptions for higher-risk medicines were dispensed when the person presented to collect them, and these medicines were handed out by the pharmacist. This gave the pharmacist the opportunity to speak with these people about their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped minimise the chance of these medicines being supplied when the prescription was no longer valid. 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 relevant warning cards were attached to the medicine boxes. The SI said that these were routinely supplied with the relevant patient information leaflet.

The pharmacy had improved its expiry date checking routine since the last inspection. Stock was stored in an organised manner in the dispensary and medicines were kept in their original packaging. Expiry dates were checked every three months and this activity was recorded.

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. Prescriptions were not always kept with dispensed items until the medicines were collected. This could make it harder for team members to refer to the original prescription if there was a query.

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. And the patient information leaflets were routinely supplied.

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 did not currently ask people to sign for their medicines due to the ongoing pandemic. 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. But it had extended this to people over 70 years old and those who were clinically vulnerable.

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, and any action taken was recorded and kept for future reference.

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. The team wore masks while at work to help minimise the spread of infection. Hand sanitiser was also available and used frequently.

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.