General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Asif's New Pharmacy, 249-251 London Road, Hadleigh, BENFLEET, Essex, SS7 2RF

**Pharmacy reference:** 1030987

**Type of pharmacy:** Community

**Date of inspection:** 07/11/2019

## Pharmacy context

The pharmacy is located on a parade of shops on a busy main road in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, emergency hormonal contraception, a stop smoking service (Champix), and a diabetic monitoring service. The pharmacy is part of a referral service to an eye clinic and podiatrist. 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 to a medium size care home. And it provides substance misuse medications to a small number of people.

## 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. 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. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. 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 been previously recorded, and these had been reviewed for any patterns. But the log had not been completed for a couple of months. The pharmacist said that he would encourage team members to record their own mistakes. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that he was not aware of any recent incidents. Posters in the dispensary displayed a list of medicines that looked alike and sounded alike. And there was a list of medicines which needed extra care during the storage, dispensing, checking and handing out. These were highlighted during the dispensing process.

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.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would open if the pharmacist had not turned up. She knew that she should not sell any pharmacy-only medicines or hand out dispensed items before the responsible pharmacist had arrived, but team members thought that they could sell General Sales List medicines during this time. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The emergency supply record was completed correctly and there were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. All necessary information was not recorded when a supply of an unlicensed medicine was made. The pharmacist said that he would ensure that all necessary information was recorded in the future. The private prescription records were completed correctly. But,

there were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that he would remind team members to check the validity of all prescriptions before dispensing them. The right responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. But, there were several occasions where there had been two pharmacists signed in as responsible pharmacist during the lunch hour. The pharmacist said that he would ensure that it was 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 pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 survey were displayed in the shop area and were available on the NHS website. Results were generally positive and 100% of respondents were satisfied with the pharmacy overall. But 25% of respondents had complained at the length of time it took for a team member to answer the phone. Following this, team members had been reminded to answer the phone within three rings where possible. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area.

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

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with some training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

### Inspector's evidence

There was one pharmacist, one trained dispenser, two trainee dispensers and two trained medicines counter assistants (MCAs) working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist explained that team members had access to online training modules and he encouraged them to complete these, but these were not done one a regular basis. A pharmacy messaging group was used to pass on important information to all team members. The pharmacist kept team members updated about any ongoing campaigns, including the recent stop smoking campaign and antibiotic campaign. He also informed them about the influenza vaccination criteria. He added photos of medicines in similar packaging to the messaging group, to help minimise the chance of mistakes being made when dispensing these.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He had recently completed training about sepsis, risk management and dementia management. He had completed declarations of competence and consultation skills for the services offered, as well as associated training. He explained that he wrote some handover notes when he knew that a different pharmacist was covering, to ensure that important information was made available to them. He said that he felt able to take professional decisions.

Team members had appraisals and performance reviews with the owner every six months. The pharmacist explained that these were more frequent if there were any issues or training needs had been identified. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Team members had regular ongoing informal meetings to discuss any issues.

Targets were not set for team members. The pharmacist said that he carried out the services for the benefit of the people who used the pharmacy.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy was co-located with a post office. The post office opened later than the pharmacy and closed earlier. Post office staff could not access the pharmacy outside of the pharmacy's opening hours. 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 separate counters in the pharmacy, one was for people to use when dropping off or collecting prescriptions and the other was for people who wished to purchase over-the-counter medicines. This helped to minimise the time taken to be served. There were seven chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

There were two consultation rooms in the pharmacy. Both were accessible to wheelchair users and located in the shop area. They were suitably equipped and well-screened. The main consultation room was not kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

The pharmacy toilet facilities and the kitchen area were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

## Principle 4 - Services ✔ Standards met

### Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and generally stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. 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 step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the dispensary and medicines counter 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 induction hearing loop appeared to be in good working order.

The pharmacy regularly received communications on PharmOutcomes from local hospitals about people's prescriptions and it often received discharge letters. This was part of the Electronic Medicines Optimisation Pathway, which helped the pharmacy to identify changes in people's medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not always kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Some prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. But this was not consistent. The pharmacist said that he would ensure that these were all highlighted in the future. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to reduce the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist 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 the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every few months and this activity was recorded. Some short-dated items were marked, but this was not consistently done. There were several date-expired items found in with dispensing stock. And one item found had expired in February 2019 with some tablets inside the box which had expired in 2018. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. 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 pharmacist said that he would ensure that the date-checking routine was kept up to date, and he would remind team members to ensure that medicines were kept in their original packaging.

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, but not until the items were collected.

This could make it harder for team members to refer to the original prescription when medicines were handed out. The pharmacist said that prescriptions would be kept with the dispensed medicines in the future. The pharmacist said that uncollected prescriptions were checked regularly and people were sent a text message reminder if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that assessments were carried out by people's GPs if they had their medicines in multi-compartment compliance packs, to show that the packs were needed. There were several team members who could manage the system. Prescriptions for people receiving their medicines in multi-compartment compliance 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 trainee dispenser said that the pharmacy contacted people to see 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. But medication descriptions were not put on the packs to help people and their carers identify the medicines and patient information leaflets were not always supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The trainee dispenser said that he would ensure that these were supplied in the future. Care homes ordered their own prescriptions and provided the pharmacy with a list of items which had been ordered. The pharmacy informed them about any missing items and the care home was responsible for contacting the surgeries about these.

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 pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. Team members had undertaken some training on how the system worked. The pharmacist said that the pharmacy had previously been using the equipment fully but the scanner had not been working for a while. He had informed the pharmacy's head office and was waiting for the scanner to be fixed.

## 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 and 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. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. 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.

## 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. |