

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: 03/06/2024

Pharmacy context

The pharmacy is located on a parade of shops on a busy main road in a largely residential area. It provides NHS dispensing services, the New Medicine Service, The Pharmacy First service, a hypertension service and flu and COVID vaccination services. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restriction imposed.

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 the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information well. And people using the pharmacy can provide feedback about its services. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. Team members could not access the pharmacy in the morning until the pharmacist had turned up. They knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. 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. Learning points were also shared regularly by the RP on a messaging group chat. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The responsible pharmacist (RP) said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The complaints procedure was available for team members to follow if needed. The RP said that there had not been any recent complaints.

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

The right RP notice was clearly displayed, and the RP record was completed correctly. And the pharmacy had current professional indemnity insurance. The RP said that the private prescription and emergency supply records were locked in a cabinet in the dispensary and the person who updated the records had the key on them. The private prescription records were checked during the last inspection and appeared to be completed correctly. The RP said that he would ensure that these records were accessible in future. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals.

At the previous inspection, it was found that the pharmacy did not always store its medicines securely and some people's personal information could be seen from the shop area. The pharmacy had implemented an action plan and had embedded the improvements. At this inspection it was seen that these items were not accessible to people using the pharmacy and patient identifiable information could not be seen. Confidential waste was removed by a specialist waste contractor, computers were

password protected and 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.

Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and they would refer any concerns to the pharmacist. The RP gave examples of action he had taken in response to safeguarding concerns. 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 team members to provide its services safely. And team members can take professional decisions to ensure people taking medicines are safe. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions.

Inspector's evidence

There were two pharmacists (one was also the superintendent pharmacist (SI)), two trained dispensers and four trainee dispensers working during the inspection. The RP explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. They worked well together during the inspection and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. One, when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members asked people relevant questions before selling over-the-counter medicines to establish whether the medicines were suitable for the people they were intended for.

Team members had access to online training modules. They said that the RP monitored their training and printed certificates when they had completed modules. The RP was aware of the continuing professional development requirement for professional revalidation. He explained that he had recently undertaken some training about inhaler techniques, the Pharmacy First service and the COVID vaccination service. He said that he felt able to make professional decisions. The pharmacists had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members explained that there were no formalised team meetings, but messages were passed on informally during the day. The team also used a messaging chat group to ensure that information was passed on to all team members promptly. Even those who were not working on the day.

Team members had formalised performance reviews twice a year. And they received informal ongoing feedback throughout the year. They felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The RP said that the services were offered for the benefit of the people using 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 bright, clean, and tidy throughout which presented a professional image. And it was secured from unauthorised access. 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, and the room temperature was suitable for storing medicines.

There were several chairs in the shop area for people to use while waiting. The pharmacy had several consultation rooms. These were all accessible to wheelchair users and were in the shop area. They were suitably equipped and well-screened. The rooms were not locked when not in use and there were some in-use sharps bins and other items potentially accessible to people using the pharmacy. A team member locked the rooms during the inspection and the RP said that he would ensure these were kept locked when not in use in future. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And 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 who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access to the front of the pharmacy through a wide entrance with an automatic door. The pharmacy could also be accessed from the car park to the rear. Team members had a clear view of the main entrance from the medicines counter. 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. And the pharmacy could produce large print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. The SI said that the local GPs would not issue a prescription for a person taking a higher-risk medicines such as warfarin and methotrexate if they needed a blood test. He said that he would speak with people about their medicines when they collected them. Prescriptions for Schedule 3 CDs were highlighted, prescriptions for Schedule 4 CDs were not. The SI said that he would consider marking prescriptions for these medicines to help minimise the chance of them being supplied when the prescription was no longer valid. The RP said team members checked CDs and fridge items with people when handing them out. And the bag was labelled to indicate that a fridge item was inside to help people know how to store these medicines properly. The SI said that the pharmacy supplied valproate medicines to a few people. He explained that team members spoke with people taking these medicines to ensure they were on a Pregnancy Prevention Programme (PPP) if they needed to be on one. The pharmacy had the relevant patient information leaflets or warning cards available. The SI said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The RP had shared the new legislation relating to gonadotropin medicines in the pharmacy's messaging group.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The RP explained the action the pharmacy took in response to any alerts or recalls. 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 RP routinely shared updates in the pharmacy's messaging group chat.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked at regular intervals and this activity was recorded. Some short-dated items were marked. But this was not consistent. There was one date-expired item found in with dispensing stock during a spot check. Medicines were kept in their original packaging. The SI said that he would implement a more reliable date checking routine.

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 separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. At the previous inspection, the pharmacy could not demonstrate that it stored all its medicines requiring cold storage appropriately. The pharmacy had implemented an action plan and had embedded the improvements. At this inspection it was seen that the fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

Part-dispensed prescriptions were checked frequently. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. The pharmacist said that uncollected prescriptions were checked monthly, and people were sent a text message reminder if they had not collected their items after around 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 RP said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. 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. One of the dispensers 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 it also kept any hospital discharge letters for future reference. Patient information leaflets were routinely supplied, and medication descriptions were put on the packs to help people and their carers identify the medicines. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack.

Deliveries were made by delivery drivers. The pharmacy obtained people's signatures for CD 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. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

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. Triangle tablet counters were available and clean. And separate counters were marked for cytotoxic use only. This helped avoid any cross-contamination. 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 SI said that the blood pressure monitors were replaced in line with the manufacturer's guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.