General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nutan Pharmacy, 456 Ashingdon Road, Ashingdon, ROCHFORD, Essex, SS4 3ET

Pharmacy reference: 1031339

Type of pharmacy: Community

Date of inspection: 10/10/2019

Pharmacy context

The pharmacy an independent family-run business. It is located on a parade of shops and it is surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 75% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and influenza vaccinations. And 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.

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 not all met	1.7	Standard not met	The pharmacy does not always protect people’s personal information.
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 not all met	4.3	Standard not met	The pharmacy does not have an adequate date-checking routine and does not always keep medicines in appropriately labelled containers. This could increase the risk of people getting medicine which is past its 'use-by date'. The pharmacy does not store medicines which need cold storage properly. This makes it more difficult for the pharmacy to know that the medicines are safe to use. It does not always store its medicines in accordance with relevant legislation. This makes it harder to show that they are kept securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. But it doesn't always protect people's personal information. It regularly seeks feedback from people who use the pharmacy. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with its activities. Standard operating procedures (SOP) were available at the pharmacy but there were no details about when these had been implemented or who had authorised them. The superintendent (SI) pharmacist said that he would ensure that this information was recorded on all SOPs. He also said that he would ensure that all team members had read and understood them, and he would keep a record of this.

The dispenser said that near misses were highlighted with the team member involved at the time of the incident, and they identified and rectified their own mistakes. She said that near misses were not always recorded due to time constraints. A near miss log was available but this had not been used for a long time. The SI said that he would encourage team members to record their own near misses and he would review these for patterns. He said that dispensing incidents would be recorded on a designated form and a root cause analysis would be undertaken. But he was not aware of any recent incidents.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Dispensing and checking areas were kept free from clutter. 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 team members' roles and responsibilities matrix had not been completed in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would remain closed if the pharmacist had not turned up. She knew that she should not hand out dispensed items or sell any pharmacy-only medicines if the pharmacist was not present in the pharmacy. The dispenser confirmed that she would carry out dispensing tasks if there was no responsible pharmacist signed in. The inspector reminded her what she could and shouldn'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. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were mostly completed correctly, but the correct prescriber's details were not usually recorded. The nature of the emergency was not always 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. 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. The recorded quantity of one CD item checked at random was the same as the physical

amount of stock available. The correct RP notice was clearly displayed and the responsible pharmacist (RP) log was largely completed correctly. But there were several occasions when the log had not been completed when the pharmacist had finished their shift.

Confidential waste was removed by a specialist waste contractor, but not all of it was kept secure. And some people's personal information was not properly protected from unauthorised access. Computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used her own smartcard to access the NHS electronic services. The SIs smartcard was being used in one of the computers while he was not in the pharmacy. The pharmacist said that the dispenser's smartcards were blocked and they had not had chance to get these unblocked. Most of the bagged items waiting collection could not be viewed by people using the pharmacy. But there was a bag of dispensed items on the counter at the start of the inspection. This was moved into the dispensary by a member of the team when prompted.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were generally positive overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The SI said that he was not aware of any recent complaints.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some of the other team members had completed some safeguarding training provided by the pharmacy. The SI said that he would ensure that the drivers undertook some safeguarding training. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI said that there had not been any 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 team members to provide its services safely. They can raise any concerns or make suggestions. 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. But they are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up-to-date.

Inspector's evidence

There were two pharmacists (one was the SI), one trained dispenser, one trainee dispenser and one trained MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. But, the dispenser was regularly distracted when assembling multi-compartment compliance packs to serve at the counter.

The trainee dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed 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.

All team members had either completed an accredited course for their role, or were enrolled on a course. The trainee dispenser had completed a counter assistant course and had recently been enrolled on a dispenser course so that she could also work in the dispensary. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some.

The pharmacists were aware of the Continuing Professional Development requirement for the professional revalidation process. The SI said that he had recently completed some eczema and dermatitis training due to a few people requesting advice about these. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. The SI said that people were asked to return on a day when the other pharmacist was working and an appointment system was used.

The pharmacist said that team members had informal appraisals and performance reviews, but these were not documented. The dispenser said that she felt comfortable about discussing any issues and concerns with the pharmacist. And she felt that the pharmacists valued her feedback about locum pharmacists who had worked at the pharmacy. She said that she was going to suggest having a rota in the dispensary so that team members carried out a variety of tasks.

Targets were not set for team members. The SI said that the pharmacy provided services for the benefit of people who used the pharmacy rather than to meet any targets or for financial incentives. He said that he would not let his professional judgement be affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But the pharmacy could do more to keep some areas tidy and free from tripping hazards.

Inspector's evidence

The pharmacy was secured from unauthorised access. Pharmacy-only medicines were mostly kept behind the counter. But some were in a delivery box on the counter and these were accessible to people using the pharmacy. These were moved during the inspection. But more pharmacy-only medicines were left unattended on the medicines counter during the inspection. The inspector reminded team members about the importance of ensuring that these medicines were not accessible to people using the pharmacy. 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 a small padded bench in the shop area. This was positioned away from the main area of the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy had two consultation rooms. One of the rooms was used by a chiropodist and there was a chair in the shop are for people to use if needed. The pharmacy’s main consultation room was located in the shop area near to the dispensary and it was not kept secured when not in use. It was suitably equipped and accessible to wheelchair users. Low-level conversations in the consultation room could not be heard from the shop area. There was some clear glass in the door and this was see-through. The pharmacist said that she asked people to move to the corner of the room out of view of the shop area if needed. The sinks in the consultation room and in the dispensary required cleaning. This was discussed with the pharmacist during the inspection and she provided assurances that this would be done.

There were several baskets containing medicines in stacks on the floor in the dispensary. These presented tripping hazards for team members and increased the chance of items being transferred to a different basket. The dispenser moved these onto the worktop during the inspection. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy obtains its medicines from reputable sources, but it doesn't always manage them well or store them properly. It doesn't routinely check the expiry dates of its medicines and this could increase the risk of people getting medicines which are past their 'use-by' date. It doesn't ensure that all its medicines are kept in appropriately labelled packs, and doesn't store all its medicines in-line with legislation. And it doesn't store medicines which need cold storage properly, which makes it more difficult for the pharmacy to know if these medicines are still safe to use. However, the pharmacy otherwise manages its services adequately. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and medical 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 with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The SI said that he did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of any checks made 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 and 4 CDs were not always highlighted. This may increase the chance of these being handed out 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 did not have the patient information leaflets or warning cards available. The SI said that he would order replacements.

Stock was not stored in an organised manner in the dispensary. The shelves were crowded and different medicines and strengths were stacked on top of one another. Expiry dates had not been checked for some time and short-dated stock was not marked. There were several date-expired items found in with dispensing stock. And several medicines were found which were not kept in their original packaging. The packs they were in did not include all the required information on the container such as batch numbers or expiry dates. There were several boxes containing mixed batches found with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

Fridge temperatures were checked daily. Records indicated that the temperatures were consistently within the recommended range. But the maximum temperature of one of the fridges was 21 degrees Celsius. The dispenser had not been resetting the thermometer properly or reading the maximum temperature properly. The inspector showed her how to do this during the inspection. The temperature on the day of the inspection was within the recommended range. The temperature display on the second older fridge was broken. It was not clearly displaying the numbers. The fridge was used for storing medicines. The SI said that he would ask an engineer to check this and replace if needed.

The SI said that part-dispensed prescriptions were checked daily. '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 not kept at the pharmacy until the remainder was collected. This could make it harder for team members to refer to the original prescription when items were handed out. And this could potentially increase the chance of items being handed out after the prescription was no longer valid. Uncollected prescriptions were checked monthly and items were returned to dispensing stock after around three months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The SI said that assessments were carried out by the pharmacy for people who received their medicines in multi-compartment compliance pack to show that it was needed. He said that people were often referred from their GP. 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 by the pharmacy; the dispenser said that people usually contacted the pharmacy when they needed them with their packs. 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 the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The dispenser that she would ensure that these were attached in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

Not all CDs were stored in accordance with legislation. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were mostly clearly marked and segregated in the cabinet. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

eliveries were made by delivery drivers. The pharmacy did not obtain people's signatures for all deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The SI said that he would ensure that signatures were obtained in future. When the person was not at home, the delivery was usually 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. The SI said that he actioned the drug alerts and recalls which the pharmacy received from NHS and the MHRA. But no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response. He said that he would record any action taken and keep on the email system for future reference.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The SI said that he carried out a trial with the equipment to make sure it worked, and the pharmacy had received a procedure for this but he had not printed it yet. The SI said that he planned to use the equipment fully before the end of the current year.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely 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. Methotrexate mostly came in foil packs and there was little need for the loose tablets to be counted out in a triangle. The dispenser said that she ensured that the triangles were cleaned after each use and tweezers were available to use if needed.

Up-to-date reference sources were available in the pharmacy and online. The SI said that the blood pressure monitor had been in use for around one year. 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.