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: 20/08/2020

Pharmacy context

The pharmacy is 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 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews and the New Medicine Service. 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. The inspection was carried out during the Covid-19 pandemic.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information and people who use the pharmacy can provide feedback about its services. 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.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. Standard operating procedures (SOPs) 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 had planned to do this following the last inspection, but he had prioritised other tasks due to the Covid-19 pandemic. There was a record to show that the team members had read and understood the SOPs. The SI said that he was in the process of carrying out Covid-19 workplace assessments. He had also considered the impact on the running of the pharmacy and who he would have to report to if a member of the team tested positive for the coronavirus.

Near misses, where a dispensing mistake had been identified before the medicine had been handed out, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. The SI said that near misses were not usually recorded, but this was something that he had considered implementing before the coronavirus pandemic. He said that he would implement a more structured recording and review process in the near future to help the pharmacy to learn from any mistakes. The SI said that he was not aware of any dispensing errors where a dispensing mistake had reached a person. He said that any dispensing errors would be recorded on a designated form and a root cause analysis would be undertaken.

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 trainee dispenser said that pharmacy would open if the pharmacist had not turned up in the morning. She confirmed that she would contact the SI if the pharmacist had not arrived. She knew that she should not hand out dispensed items or sell any medicines if there was no responsible pharmacist (RP). And she confirmed that she would carry out any dispensing tasks if there was no RP signed in.

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 always recorded. The nature of the emergency was recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. 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) record was largely completed correctly. But there were several occasions when the record had not been completed when the pharmacist had finished their shift. The SI said that he would remind all pharmacists to ensure that the RP record was completed correctly in the future.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Team members used their own smartcards to access the NHS electronic services. The locum pharmacist had his personal smartcard available if needed. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had carried out a patient satisfaction survey from 2017 to 2018 and the results were available on the NHS website. The pharmacy had questionnaires available for people to complete if they wanted. 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 SI and locum pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some of the other team members, including the delivery drivers had completed some safeguarding training provided by the pharmacy. The medicines counter assistant (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, and 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 enrolled on accredited courses in a timely manner. And, although they get some ongoing training, this is not done on a regular basis. This could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one locum pharmacist working at the pharmacy at the start of the inspection. The pharmacist contacted the SI to make him aware that the pharmacy was having an inspection carried out. The SI attended the pharmacy shortly after being called. Other team members working during the inspection included, one trained dispenser, two trainee dispensers and one trained MCA. The team members 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. 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.

Some team members had completed an accredited course for their role, and some others were enrolled on suitable courses. One of the trainee dispensers said that she had had worked part-time at the pharmacy for several years, but she had not been enrolled on an accredited training course for her role. Following the inspection, the SI provided confirmation that the trainee dispenser had been enrolled on a suitable course. The SI 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 learning about the coronavirus and pharmacist consultations.

The SI said that team members had informal appraisals and performance reviews, but these were not documented. The MCA 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.

Targets were not set for team members. The SI said that the pharmacy provided services for the benefit of people who used the pharmacy. He said that he would not let his professional judgement be affected.

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. Pharmacy-only medicines were mostly kept behind the medicines counter. But some were on shelves next to the counter and these were accessible to people using the pharmacy. The SI said that he would ensure that these items were not available for self-selection in the future. 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 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. There was a cross on the middle seat to discourage people from using this one and maintain a suitable distance from each other. And this had been done as part of the pharmacy's response to the COvid-19 pandemic. A notice was displayed at the entrance to the pharmacy asking that only six people were in the shop area at a time. A one-way system had been implemented in the shop area to help people to maintain a suitable distance. Chairs were being used at the counter and a screen had been installed to help protect the pharmacy team during the pandemic.

The pharmacy had two consultation rooms. One of the rooms was used by a chiropodist and there was a chair in the shop area for people to use if needed. The pharmacy’s main consultation room was located in the shop area near to the dispensary. 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. 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

Overall, the pharmacy manages its services well. The pharmacy gets its medicines from reputable suppliers and 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.

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 had implemented monitoring record book checks for people taking higher-risk medicines such as methotrexate and warfarin. And a record of checks made had been kept. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. This process had been recently put on hold due to the Covid-19 pandemic to help minimise the risk of spreading the virus. The SI said that prescriptions for higher-risk medicines were highlighted. So that there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these being handed out when the prescription was no longer valid. The SI 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 at regular intervals and short-dated items were highlighted. There were no expired items found with dispensing stock and medicines were kept in their original packaging.

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 kept at the pharmacy until the remainder was collected. This made it easier for team members to refer to the original prescription when items were handed out. 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 packs to show that these were 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 SI 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 SI that he 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.

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 clearly marked and kept separate in the cabinet. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by delivery drivers. The pharmacy did not currently ask for people to sign for their items due to the risk of spreading the coronavirus. The SI said that the drivers maintained distance from people when making the deliveries. 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. And a record of any action taken was kept, which 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. 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. The SI said that the pharmacy planned to use the equipment fully in the near future.

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

Fridge temperatures were checked daily. Records indicated that the temperatures were consistently within the recommended range. The temperature display on the second fridge was previously broken and it had not been clearly displaying the numbers. The SI said that it had been checked by an engineer and the display had been replaced.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had face masks, alcohol gel, visors and gloves available for team members to use. Most of the team were wearing masks during the inspection and there was sufficient room in the dispensary for them to maintain a suitable distance.

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.