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: 02/08/2022

Pharmacy context

The pharmacy is located on a small parade of shops in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. And the pharmacy 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 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 not all met	4.3	Standard not met	The pharmacy does not always store its controlled drugs securely.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages most of the risks associated with its services. It largely protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy mostly keeps its records up to date and accurate. 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

There was a set of standard operating procedures (SOPs) in the pharmacy. Team members explained how near misses, where a dispensing mistake was identified before the medicine had reached a person, were dealt with. The near misses were passed back to the person who had dispensed the medicines for them to identify and rectify their own mistakes. But the pharmacy did not keep a record of near misses, which made it harder for the pharmacy to identify 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 dispenser was not aware of any recent dispensing errors, where a dispensing mistake had reached a person. She was not sure where these would be recorded if one happened.

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

The dispenser said that the pharmacy would open if the pharmacist had not turned up in the morning. She knew which tasks should not be carried out if there was no responsible pharmacist (RP). And she would signpost people to another local pharmacy if needed. She confirmed that she would not hand out any bagged items or sell any pharmacy-only medicines if the pharmacist was absent from the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. 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 right RP notice was clearly displayed and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the prescriber's name and date of prescription was not routinely recorded. This could make it harder for the pharmacy to find these details if there was a future query. 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. And this could make it harder for the pharmacy to show why the medicine was supplied if there was a query.

People using the pharmacy could not see information on the computer screens or on the bagged items waiting collection. Confidential waste was removed by a specialist waste contractor and computers were password protected. But the passwords were displayed at the computer stations. The inspector made team members aware of the risks with sharing passwords and they agreed to remove them. The pharmacist had his own smartcard to access the NHS electronic services. But team members were using

smartcards which belonged to the owners who were on leave on the day of the inspection. And the personal identification numbers were recorded on the smartcards. Team members said that they did not have their own smartcards. Following the inspection, the owners confirmed that two team members had smartcards which could be used in their absence.

The pharmacy had not carried a patient satisfaction survey since the start of the pandemic. The dispenser said that she was not aware of any recent complaints. She would inform the pharmacist if someone wanted to make a complaint. But she could not locate the pharmacy's complaints procedure during the inspection.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members 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 manage its workload and provide its services safely. The team members can take professional decisions to ensure people taking medicines are safe. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. But the pharmacy does not always enrol people on an appropriate training course in a timely manner.

Inspector's evidence

There was one locum pharmacist, two trained dispensers (one was a locum employed to cover leave), and a trainee medicines counter assistant (MCA) working during the inspection. There was also a member of staff working as a dispenser, who said that they had worked 'on and off' at the pharmacy since around 2018. But they had not been enrolled on an accredited course. The pharmacy addressed this immediately following the inspection and provided evidence to the inspector that the member of staff had been registered on an appropriate course. The team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of medicines containing pseudoephedrine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked questions to establish whether the over-the-counter medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to take professional decisions. He explained that he had recently undertaken some training for the Covid vaccination service and about safeguarding children and vulnerable adults. The dispenser said that the regular pharmacists usually passed on important information to help keep their knowledge up to date. But the team did not receive regular ongoing training. The dispenser said that every morning, messages were sent to the group chat to let team members know what tasks needed to be completed and who by. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They received informal ongoing appraisals but these were not documented. 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. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which 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 and the room temperature was suitable for storing medicines

There was a padded, wipe-clean bench in the shop area for people to use. This was positioned to the side of the medicines counter and away from people waiting to be served. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and 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 not all met**

Summary findings

The pharmacy does not always store its controlled drugs securely. But otherwise, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls so that people get medicines and medical devices that are safe to use. The pharmacy dispenses medicines into multi-compartment compliance packs safely. But it does not 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

Services and opening times were clearly advertised and a variety of health information leaflets was available. And there was step-free access to the pharmacy through a wide entrance with an automatic door. Team members had a clear view of the main entrance from the medicines counter which meant that they could help people into the premises where needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin if available. He said that he would record the results on the patient's medication record. 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 CDs were highlighted, but prescriptions for Schedule 4 CDs were not. And one of the team was unsure how long these prescriptions were valid for. This could increase the chance of these medicines being supplied when the prescription is no longer valid. One team member 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. Warning cards were attached to the medication packaging, but team members were not aware that these could be removed to create space to place the dispensing label so that important information was not covered. The pharmacy did not have the relevant patient information leaflets or warning stickers available. The dispenser said that she would order some from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next several months was marked. There were no date-expired items found in with dispensing stock.

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 dispenser said that uncollected prescriptions were checked regularly and uncollected items were returned to dispensing stock where possible. And the prescriptions were returned to the NHS electronic system or to the prescriber.

The dispenser said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their

medicines. The pharmacy did not order prescriptions on behalf of people who received their medicines in the packs. Prescriptions for 'when required' medicines were not routinely requested. The dispenser said that the people usually requested these 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 patient information leaflets were routinely supplied. The batch number and expiry date of the medicines were recorded on the backing sheets.

Expired CDs were kept separate from dispensing stock in the CD cabinet. Denaturing kits were available for the safe destruction of CDs. But patient-returned CDs were not always kept secure. The issue of CD security had been raised with the pharmacy on a previous inspection. Patient-returned CDs were recorded in a register and destroyed with a witness, and 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. This made it easier for the pharmacy to show that the medicines were delivered to the right address. The delivery driver said that he attempted to deliver fridge items first, and he delivered to different areas on different days to help minimise the time taken to make the deliveries. 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. The dispenser said that the pharmacist made the team aware of any drug alerts and recalls and these would be actioned promptly, but she was not sure if any action taken was recorded.

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

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring liquids and counting tablets was available and largely clean. Some of the measures were not clean, and the dispenser said that she would ensure that these were thoroughly cleaned. A separate counter was 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. The phone in the dispensary was portable so it could be taken to a more private area where needed.

The fridges were suitable for storing medicines and were not overstocked. The dispenser explained how she checked the fridge temperatures each day. But she had not been recording the maximum temperature, she had been recording the current temperature instead. And she had not been resetting the thermometer after checking the temperatures. The maximum temperature for each thermometer was over 26 degrees Celsius. The current temperatures during the inspection were within the recommended range. And the thermometers integrated into the fridges were showing that the maximum temperatures had been within the recommended range. The inspector showed the dispenser how to reset the external thermometers and check the maximum temperatures. The dispenser said that she would ensure that the thermometers were checked and reset daily.

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.