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: 14/06/2023

Pharmacy context

The pharmacy is in a largely residential area, and it receives most of its prescriptions electronically. It provides NHS dispensing services, the New Medicine Service, and a flu vaccination service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes and need this support.

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. Team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information. And it largely keeps its records up to date and accurate. But it 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 had a generic set of standard operating procedures (SOPs) available, but team members said that these were not the ones the pharmacy currently used. The inspector had seen a different set at the pharmacy during a previous inspection. Following the inspection, the superintendent (SI) pharmacist confirmed that the SOPs were at the pharmacy. Not having the SOPs readily available may make it harder for the pharmacy team to know what the right procedures are. Team members said that if they made a dispensing mistake which was identified before the medicine had reached a person (known as a near miss), they would have to rectify it themselves. Near misses were not recorded which meant that they could not be reviewed for any patterns. But the pharmacy did separate items in similar packaging or with similar names where possible to help minimise the chance of the wrong medicine being selected. Team members said that they were not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. The pharmacist said that he would make a record of any dispensing errors and inform the SI. The complaints procedure was available for team members to follow if needed and details about it were available in the shop area. A team member said that she would refer any concerns to the SI, and he would discuss them with the team.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was free from clutter and 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 knew what they could and couldn't do if the pharmacist had not turned up in the morning. And they knew what they shouldn't do if the responsible pharmacist (RP) 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 private prescription records were largely completed correctly, but the name and address of the prescribers was not routinely 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. Team members were reminded to complete these records correctly in future. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there appeared to be a few missed entries. The pharmacist said that he would speak with the SI about this to ensure that all pharmacists completed the record correctly in future.

Bagged items awaiting collection could not be viewed by people using the pharmacy. Computers were

password protected and people using the pharmacy could not see information on the computer screens. Most confidential waste was stored securely until it was removed by a specialist contractor. But there was some confidential waste found on returned medicines in the pharmaceutical waste bins. Team members said that they would remove this in future and dispose of it appropriately. Team members were using a smartcard to access the NHS electronic services which belonged to a pharmacist who was not working on the day of the inspection. The pharmacist had his own smartcard available and said that he would use this instead.

Team members had training about protecting vulnerable people. The pharmacy technician could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She gave an example of action the pharmacy had taken in response to a safeguarding concerns. And 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. The team members can make professional decisions to ensure people taking medicines are safe. And they can raise any concerns. 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.

Inspector's evidence

There was one locum pharmacist, one locum pharmacy technician, two trained dispensers (one was a locum) and one trainee dispenser working during the inspection. Most team members had completed an accredited course for their role, and one was undertaking training.

Team members appeared confident when speaking with people. One team member, when asked, said that she would refer to the pharmacist if a person asked to purchase more than one pack of an over-the-counter medicine. She asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. And she said that she would also refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

Team members said that they were not provided with ongoing training on a regular basis, but they did receive some on an ad hoc basis. The pharmacist and pharmacy technician were aware of the continuing professional development requirement for professional revalidation. The pharmacy technician said that she also worked at a GP surgery and had recently completed the CPPE Primary Care Pathway course and vaccination training. The pharmacist said that he had recently completed the face-to-face flu training. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that information was usually passed on during the day or via the pharmacy's group chat. But there were no formalised meetings. The pharmacist felt able to make professional decisions and would escalate any issues to the SI. Team members said that they did not receive formalised appraisals or performance reviews. But any issues with their performance was discussed informally with them. 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. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep some areas tidy and free from clutter as this currently detracts somewhat from the overall appearance of the pharmacy.

Inspector's evidence

The pharmacy was bright, clean, and generally tidy throughout. It was secured from unauthorised access and 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. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

There was a padded bench in the shop area for people to use while waiting. The pharmacy's main consultation room was accessible to wheelchair users. It was in the shop area and it was suitably equipped. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was used as a storage area which detracted somewhat from the overall appearance of the pharmacy. There were parts of the door that were see-through. The pharmacist said that he would position himself in such a way to obscure people's view into the room. A second consultation room was available if additional privacy was needed. This room was mostly used by a chiropodist. It was kept locked when not in use, but the key was left in the door. And there were used sharps bins on the floor in the room. This was discussed with a team member during the inspection, and they said that this would be addressed promptly.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. And the pharmacy ensures that people who get their medicines in multi-compartment compliance packs receive all the information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. And it responds appropriately to drug alerts and product recalls. 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. Team members had a clear view of the main entrance from the 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.

Dispensed fridge items were kept in clear plastic bags to aid identification. Team members said they checked CDs and fridge items with people when handing them out. 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 (PPP). The pharmacist said that he would refer people to their GP if they weren't on a PPP and needed to be on one. 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 not those for Schedule 4 CDs. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The dispenser said that she would highlight these types of prescriptions in future.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. One of the dispensers explained the action the pharmacy took in response to any alerts or recalls. But she was not sure where the actioned alerts were kept. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, 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 and medicines were kept in their original packaging. CDs were largely 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 kept separate from stock items. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The fridges were suitable for storing medicines and were not overstocked. Team members said that fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. But the maximum temperature on one of the thermometers was showing 20 degrees Celsius and the other one was showing 12 degrees Celsius when first looked at during the inspection. The current temperatures were within the required range. Staff said the fridge doors had been opened to put stock away. The fridge temperatures went slightly above the recommended range while monitored during the inspection. Team members said that they would continue to monitor this and move the probes away from the

front of the fridge so that the warmer air from the pharmacy did not affect them when the doors were opened. There were several oxygen cylinders found in a room above the pharmacy. Following the inspection, the SI confirmed that these were empty and that he would arrange for these to be collected.

Part-dispensed prescriptions were checked regularly. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. Items remaining uncollected after around three months were returned to dispensing stock where possible. And prescriptions for these items were returned to the NHS electronic system or to the prescriber.

The dispenser said that people had assessments 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 for most people so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The dispenser said that people usually ordered 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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries of CDs and these were recorded in a way so that another person's information was protected. But it didn't obtain signatures for other items. 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. Separate liquid measures were marked for use with certain medicines 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. Team members said that the blood pressure monitor was replaced regularly. 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.