General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Govani, 87 Front Lane, Cranham, UPMINSTER, Essex, RM14 1XN

Pharmacy reference: 1031439

Type of pharmacy: Community

Date of inspection: 03/09/2019

Pharmacy context

The pharmacy is located in a village and mainly serves people who live locally. The pharmacy provides Medicines Use Reviews and New Medicine Service checks to people. And it offers an emergency hormonal contraception service.

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 not all met	3.2	Standard not met	There is a risk that people accessing the consultation room can see other people's private information.
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 generally identifies and manages the risks associated with providing its services. It largely keeps the records it is required to by law. Team members work to written procedures to help provide the pharmacy's services safely. But some standard operating procedures have not been reviewed for some time, which may mean that the information contained in them is not current. The pharmacy doesn't consistently record or review near misses which may that team members are missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place. Some of these had not been reviewed for some time including the SOP for operating in the absence of the responsible pharmacist (RP). The RP said that he would notify the superintendent pharmacist (SI) so that these could be reviewed. Some SOPs available in the pharmacy were duplicated. Team roles were defined within the SOPs. Team members had read and signed SOPs relevant to their roles.

Near misses were discussed with the team as they occurred and said to be recorded in a register. There were no near misses seen to be recorded since October 2017. The RP said that near misses were not always recorded. The technician said that some near misses were recorded on the electronic system but was unable to show any records as the pharmacy had recently upgraded their system. As a result of a previous discussion about a near miss, sertraline and sumatriptan had been moved on the shelves to avoid picking errors.

In the event that a dispensing incident was reported the RP said that he would investigate the error. This would include having a conversation with the person and find out if they had taken any of the incorrect medication and if they had to find out if they had suffered any side-effects. He would also look to see how the error had occurred and discuss with the team what changes needed to be made. In the past shelf-edges had been labelled with warning stickers. A note would also be made on the person's electronic record so that team members would take more care in the future. As a result of hearing of dispensing errors with amitriptyline and amlodipine in the news and as a team member had made a near miss, shelf-edge warnings had been placed near where both were kept.

The incorrect RP notice was initially displayed, this was changed during the course of the inspection. The team members were aware of the tasks that could and could not be carried out in the absence of the RP.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. People were referred to the pharmacy owner if they had a complaint. As a result of a person's feedback, the team ensured that prescriptions for some people were prepared in advance as the pharmacy generally did not dispense prescriptions for controlled drugs (CDs) before the person presented to collect.

Records for unlicensed medicines and RP records were generally well maintained, although one of the pharmacists was not routinely signing out of the RP record. This could make it harder for the pharmacy to show who the RP had been if there was a query. Private prescription records did not always have the correct prescriber details recorded. And this may mean that this information is harder to find out if

there was a query. Emergency supply records did not always contain a reason for supply and there was some overwriting in the CD registers. CD balances were checked. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received.

The pharmacy had an information governance policy in place which the team had read through and signed. Relevant team members who accessed NHS systems had smartcards. The two pharmacists had access to Summary Care Records (SCR); consent to access these was gained verbally. The RP had read through information booklets when the General Data Protection Regulation had come into place.

The RP had completed level two safeguarding training and verbally briefed the team. The RP said that he had noticed an increasing number of people suffering from dementia as a result of which team members had completed the Dementia Friend training. The RP also communicated with the GP if he noticed that someone was showing signs of dementia or memory loss particularly in relation to the delivery of medicines. The pharmacy did not have details available for the local safeguarding boards and this could result in delays in concerns being escalated.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members are given some ongoing training. But this is not very structured, and they are not given time set aside for training. This could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, a dispenser who had completed her NVQ level 3 training and two trained medicines counter assistants (MCAs). The owner was also a registered pharmacist and came in partway through the inspection. Another MCA who was not working at the time of the inspection was also enrolled on the dispenser training course.
The RP said that there were an adequate number of team members when everyone was in. A rota was in place to show who was covering each shift. Team members who worked part-time covered shifts when other colleagues were off sick or on leave.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She was also aware of the legal limits and age restrictions on the sale of certain medicines like pseudoephedrine. The assistant handed out prescriptions, but she was unsure of the time period that prescriptions were valid for. The pharmacy did not highlight prescriptions for Schedule 3 or 4 CDs in any way. This increased the risk of them being handed out after the prescription was no longer valid.

Performance of team members was managed by the owner who held an annual review with each individual. Pay and performance related matters were discussed as well as how team members could improve. Team members were encouraged to show how and where they had made a difference. Team members said that they felt able to discuss any issues or raise concerns with the owner, SI and RP. The RP gave team members feedback as well as providing feedback to the owners. The pharmacists from the group’s branches went for a meal every three months and used this opportunity to discuss any issues. The SI came to visit the pharmacy from time to time to check how the team were doing.

The team did not hold formal meetings but discussed things as they arose. A notebook was also used to record information if people were not in, as well as record any handover notes. This was used less frequently recently as there had been a change in shifts which had resulted in their being an overlap. The dispenser worked all week and was able to pass information on to other pharmacists. The team also used an electronic messaging application to share information.
The dispenser said that the RP and owner had supported her with her training when she had been completing her NVQ level 3 course. The RP who was the supervisor for the trainee dispenser described that the trainee was supported with her training by the pharmacists and a more experienced colleague. The RP said she generally came in on a quiet afternoon to go over her workbook and discuss any areas she was stuck on.

There was no formal process in place for completing ongoing training. The RP passed on information to team members when medication was reclassified such as from prescription-only to pharmacy-only or general sale list. Team members said that the RP also passed on information from emails or pharmacy

literature. The RP also discussed topics that he had covered for his Continuing Professional Development with the team. The team discussed informally any advertising campaigns or when seasons changed to discuss what items needed to be stocked. There were no numerical targets set for the services offered.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises are suitable for the pharmacy's services and are mostly clean and tidy. People can have a conversation with a team member in a private area. But there is a risk that people accessing the consultation room can see other people's private information.

Inspector's evidence

The dispensary was small, with limited storage and dispensing space. Some of the work benches were cluttered, however, there was an adequate amount of clear workspace available to dispense and check prescriptions safely. Stock was organised in a tidy manner on the shelves in the dispensary. Another small room was also used to hold additional stock. The retail area was well laid out and presented a professional image. Cleaning was either done by a cleaner who came in on a Saturday (although the team said that she was not regular) or team members. A sink was available for the preparation of medication.

A small consultation room was available, this was located towards the back of the dispensary. People accessing the consultation room had to walk through the dispensary, and on the way, other people's personal information was visible. The RP said that the consultation room was not used for many consultations.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature in the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are largely delivered in a safe and effective manner. The pharmacy obtains its medicines from reputable sources, and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts, but it doesn't routinely record what action it has taken. This could make it harder for the pharmacy to show what it has done in response.

Inspector's evidence

There was step-free access into the pharmacy and there was an automatic door with space in the shop for the movement of pushchairs and mobility aids. There was also easy access to the counter. Team members would help people if they required assistance. Some of the team members were multilingual or the pharmacist used online translation applications and gave an example of having to use it to translate Chinese. A delivery service was available for patients unable to attend the pharmacy. Team members knew what services were available and described signposting people to other providers if a service was not offered at the pharmacy. Team members used the internet to locate other services. There was a doctor, dentist, podiatrist and physiotherapist nearby.

The RP felt that the delivery service had the most impact as there were a number of housebound and older people. The delivery driver also kept 'an eye out' on regular people and notified the team if he had any concerns. The pharmacy did not provide many services but mainly counselled people over the counter.

Introduction of new services depended on the demand and financial return. The RP said that if he identified a new service that was needed he would have a discussion with the owner. The RP said that the pharmacy did a number of consultations and interventions but these were not recorded as Medicines Use Reviews as people were not always taken to the consultation room.

The pharmacy had an established workflow in place. Prescriptions were predominantly received electronically. Majority of the prescriptions received were from the surgery situated around the corner. Colour coded baskets were used to separate prescriptions and to manage the workflow. There were two people including a pharmacist who were involved as part of the dispensing and checking process. The RP said that it was rare that he had to self-check. In the event that he did self-check he described taking a mental break between dispensing and checking. People who wanted to have their medication supplied in multi-compartment compliance packs were signposted to the sister branch. Dispensed and checked by boxes were available on labels; these were routinely used by the team.

Team members attached a 'see pharmacist' sticker when a prescription was received for sodium valproate for someone who fell in the at-risk group. The RP was aware of the change in guidance for dispensing sodium valproate and the associated pregnancy prevention programme. The RP recalled receiving the 'Prevent' folder but had not been aware of the need to use the warning labels. The inspector reminded the RP of the requirements.

Warfarin was kept on separate shelves from the rest of dispensing stock to reduce the risk of errors. The RP said that the number of people who were prescribed warfarin had reduced over time. The RP checked people's yellow book and, on some occasions, made an entry onto the persons electronic record. Methotrexate was only ordered as blister packs rather than loose tablets and the pharmacy did

not stock the 10mg strength. The RP said that this was done to reduce the risk of error.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Expiry date checks were generally carried out on a rotating basis. A date checking matrix was in place. There were no date-expired medicines found on the shelves checked. The MCA had helped with date checking previously. The RP and owner gave assurances that this would now be delegated to the dispensary team members instead. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

The pharmacy had the equipment that it needed to comply with the Falsified Medicines Directive (FMD). The RP said that the login details provided had been incorrect and they were in the process of sorting this out. The RP expected the system to be live within the next week.

Drug recalls were received via email and were also forwarded by the owner. The team had received the more recent recall for Aripiprazole which they did not have in stock. There was no record kept of any action taken and this could make it harder for the pharmacy to show what it had done in response.

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

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines to avoid contamination. Two medical fridges of adequate size were also available.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was segregated and collected by a waste company.

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.