General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mistry Chemists, Wood Street, Isle of Sheppy, SHEERNESS, Kent, ME12 1UA

Pharmacy reference: 1032942

Type of pharmacy: Community

Date of inspection: 24/05/2024

Pharmacy context

The pharmacy is in a busy town centre next to a surgery. The pharmacy provides NHS dispensing services and the Discharge Medicines Service to people who have recently been discharged from hospital. It supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it provides substance misuse medications to some people.

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	1.1	Standard not met	The pharmacy team have not read the standard operating procedures. And there is evidence that the staff are not always following them. The pharmacy does not regularly review its procedures, and so that may not reflect current best practice. Taken together, this increases the potential risks of the services.
		1.8	Standard not met	Pharmacy team members cannot describe clearly what actions they would take to safeguard vulnerable individuals
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	4.4	Standard not met	The pharmacy does not have a robust system in place to manage drug alerts and there is no evidence to show what action has been taken in response.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

Team members are not familiar with the pharmacy's written procedures, and there is evidence that they are not following them. The pharmacy does not regularly review its procedures, so they may not reflect current best practice. Taken together, this increases the risk of something going wrong. Team members do not sufficiently know how to deal with safeguarding concerns, which means that vulnerable people using the pharmacy's services are less protected.. However, people using the pharmacy can provide feedback and raise concerns. And on the whole, the pharmacy adequately protects people's personal information. Team members usually discuss any dispensing mistakes, but they do not record them. This makes it harder for the pharmacy to review them and identify any patterns or trends. And means that team members may be missing out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). These were instructions designed to support the team in safely undertaking various processes. They had last been reviewed in 2015 they may not reflect best practice. There was a sheet for team members to sign to confirm they had read and understood the SOPs which were relevant to their role. But current members of the team had not read or signed them. And team members were observed deviating from the owings SOP, for example the team was dispensing owings against dispensing labels rather than prescriptions. This could increase the risk of dispensing errors occurring. And the controlled drugs (CD) running balance was not checked at the frequency specified in the SOPs. The Responsible Pharmacist (RP) explained that he was currently completing a full review of the SOPs.

The RP notice was displayed in a prominent position in the pharmacy and reflected the RP on duty. However, the RP notice did not match the entry in the log. The RP was made aware of this during the inspection. Generally, the RP record was maintained as required by law.

If the RP identified any errors made during the dispensing process, known as near misses, they informed the person responsible for the error and asked them to rectify the mistake. The pharmacy did not make a record of these near misses. The pharmacy recorded dispensing incidents (dispensing mistakes that had reached a person) on the person's medication record. But there was no review of these incidents, and they were not discussed within the team so the pharmacy may miss opportunities to learn from these errors and put safeguards in place to prevent future similar mistakes. A random check of two assembled prescriptions only contained initials in the dispensed box. The RP said that they were his initials and that dispensers generally did not sign the label when they dispensed. This meant that there was not always a clear audit trail of who dispensed the medication. But team members were seen initialling labels while dispensing prescriptions for people who were waiting.

The pharmacy had a notice on display in the retail area of the pharmacy with the complaint's procedure and the details of who to complain to. Team members explained people could complain or give feedback directly to the pharmacist. Professional indemnity insurance was in place and the RP said he was waiting for the renewed certificate to arrive to display.

Private prescription records and records of unlicensed medication were appropriately maintained.

CD registers seen were maintained in line with requirements. Three CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

The pharmacy team had not completed any information governance training. But confidential waste in the dispensary was kept separate to normal waste and shredded. Pharmacy team members accessed NHS electronic prescriptions using a password-protected smartcard. But some of them did not have their own card so used another team members NHS smartcard to access the data. This meant there may be an unclear audit trail of who accessed the data. The RP was advised to ensure team members had their own smartcards.

The pharmacy team members could not explain how they would manage a safeguarding concern. There was a risk the pharmacy would miss identifying a vulnerable person requiring support.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members can raise any concerns or make suggestions. They are not always provided with regular ongoing training which could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

The RP, SI and three trained dispensers were working on the day of the inspection. The RP explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. The pharmacy was up to date with its dispensing. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. One of the dispensers when asked knew 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 explained the questions she would ask people to establish whether a medicine was suitable for the person it was for.

The RP was aware of the continuing professional development requirement for professional revalidation. The RP said that he had undertaken some recent training about deep vein thrombosis and shingles. The RP said that team members were not provided with formal ongoing training, but he would inform them about any changes to regulations. The RP and other team members and were not aware of the recent changes with codeine linctus or valproate medicines, however there was no evidence that this had caused any issues. One of the dispensers said that the pharmacy did not sell codeine linctus over the counter. The RP said that he felt able to make professional decisions. He explained that he would need to discuss any potential changes with the SI before implementation.

One of the dispensers said that there were no team meetings and information was passed on informally during the day when needed. Team members did not have formalised performance reviews but said that the RP provided feedback at the time. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. 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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. 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. Pharmacy-only medicines were kept behind the counter. The RP explained that the air conditioning units were not currently working, but the pharmacy was in the process of getting new ones installed. There was a portable air conditioning unit in the shop area and the room temperature on the day of the inspection was suitable for storing medicines. There was a thermometer in the shop area displaying the room temperature.

The consultation room was suitably equipped, well-screened. A team member was using the room to undertake administrative tasks at various times during the inspection and there was patient identifiable information near the door. This could be seen from the shop area and the door was left open when the team member left the room. The RP provided assurances that the door would be kept locked when the room was not in use in future and that patient identifiable information would be protected. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and there were separate hand washing facilities available.

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

Summary findings

Team members are not always aware of safety alerts or recalls and the pharmacy does not have a robust system for responding to them. This increases the risk of supplying medicines to people that are unsuitable for use. The pharmacy's services are easy for people to access and it generally manages its dispensing services well. The pharmacy does not always highlight high-risk medicines so there is a risk people may not always get the right information about their medicine.

Inspector's evidence

The pharmacy had step free access from the pavement and a manual door. This allowed people with mobility issues access into the pharmacy. The pharmacy's main consultation room was accessible to wheelchair users and was in the shop area. There was seating available for people to use while they waited for their prescriptions. And there was a range of healthcare leaflets available to people for a variety of health topics.

Prescriptions were generally dispensed when people came to collect their medicines. Team members used baskets to separate prescriptions and reduce the chance of prescriptions getting mixed up. Some prescriptions containing a larger number of items were dispensed ahead of the person coming in to collect. And the assembled bags were stored in the dispensary.

The pharmacy dispensed medicines in multi-compartment compliance packs for a few patients. One dispensed pack seen was sealed and labelled with a description of the medicines inside. This included a description of the colour, shape, and any markings on the medicines to help people identify their medicines. And team members had initialled to show who had dispensed the packs. The prescriptions and empty medicines boxes were kept with the packs for the pharmacist to check.

Team members did not have a process to identify people taking higher-risk medicines such as lithium or warfarin. This meant there was a risk people did not always receive the right information or advice to ensure these medicines were taken safely. The RP was aware of the risks in pregnancy associated with valproate containing medicines. He explained that he would provide additional counselling to people who were dispensed these medicines and that they were supplied in their original packs. Team members showed on the packaging where they had been placing the dispensing labels. They were shown where to apply a dispensing label so as not to obscure important safety information on the pack.

The pharmacy obtained its medicines from licensed wholesale dealers and specials suppliers. The medicines were stored in a tidy way in the dispensary. Some work on fixtures and fittings had recently been carried out in the dispensary to provide more storage for medicines. One of the dispensers confirmed that the stock was date checked regularly and short-dated medicines were recorded so they could be identified and removed at the appropriate time. A random selection of stock was checked during the inspection and no date-expired medicines were found. There was a fridge in the dispensary for medicines which required cold storage. Temperature checks were carried out daily and recorded. And they were seen to be within the appropriate range. CDs requiring safe custody were stored securely as required. Patient returned medicines were stored separately from stock medication. But there was a pharmaceutical waste container in the toilet area with what appeared to be patient-returned medicines. This made it harder for the pharmacy to show that these medicines were being

kept securely. The RP provided assurances that these medicines would not be kept in the toilet area in future.

The pharmacy did not receive MHRA drug alerts and recalls and there was no system in place to manage safety alerts. There was therefore no evidence to show that any previous alerts had been actioned. The RP was shown how to sign up for the alerts to be received via email from the MHRA. Team members were not aware of any recent patient safety alerts and so no action had been taken with regards to these. This meant that there was a risk that medicines may be supplied to people which are not suitable. The inspector checked the stock for the most recent drug recall, but the pharmacy did not have any of the affected batch in stock.

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 and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. And 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. Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. 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.