General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Niva Pharmacy Limited, 2 Uppingham Road, LEICESTER, Leicestershire, LE5 0QD

Pharmacy reference: 1034164

Type of pharmacy: Community

Date of inspection: 11/08/2022

Pharmacy context

This is a community pharmacy that is situated on a main road in the outskirts of Leicester. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes and in supported accommodation. Other services that the pharmacy provides include delivering medicines to people's homes.

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 identifies and manages the risks associated with the provision of its services. It generally keeps the records it needs to by law. And the pharmacy manages people's personal information safely. The pharmacy has suitable procedures to learn from its mistakes.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). Staff said that they had read and signed the SOPs but there were no records of this in the pharmacy. Staff didn't always follow the SOPs. For example they didn't always sign the 'dispensed by' box on the medicine label.

The pharmacy aimed to use a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label. But some original packs checked had the 'checked by' box signed by the pharmacist but the 'dispensed by' box wasn't signed. This meant it would be more difficult to find out who had dispensed a medicine if something went wrong. The pharmacist said that she would make sure the team signed the 'dispensed by' box.

The pharmacy had processes for reviewing dispensing mistakes that were identified before reaching a person (near misses) and recording dispensing mistakes where they had reached the person (errors). However because the team members didn't always sign the 'dispensed by' box on the medicine label, the pharmacy may find it harder to review these events fully. Near misses were discussed with the member of staff at the time and recorded in the near miss log. The pharmacist reviewed the near miss log and discussed the outcomes at the regular team meeting. The trainee pharmacist highlighted several actions that had been taken with a specific medicine following several near misses.

When asked a team member could recall most but not all of the questions that would be routinely asked when a person visiting the pharmacy asked to buy an over-the-counter medicines. The team member said he would refresh his knowledge. The trainee pharmacist explained that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. However when the trainee pharmacist was asked about a specific medicine that was waiting collection he thought that it had a 6-month validity. But because it was a Schedule 4 CD it was only valid for 28 days. He said he would review his knowledge of prescription validity. The prescriptions waiting collection that included a CD that had a 28-day expiry weren't highlighted to remind staff of the shorter validity. This increased the risk that a medicine might be handed out when the prescription was no longer valid.

When the inspector arrived at the pharmacy the responsible pharmacist (RP) notice on display was hidden behind a stack of medicines. The pharmacist moved it to a position where people could see it. The pharmacy mainly maintained the necessary records to support the safe delivery of pharmacy services. These included the RP log and the CD registers. Private prescriptions were recorded electronically, and the examples checked either didn't record all the details or the details were incorrect. The pharmacist said that she would make sure the correct details were added.

The pharmacy carried out regular checks of the physical quantity of CDs to make sure that they matched the balances in the CD register but these were not always done on a regular basis. A random

check of the recorded running balance of a CD didn't match the actual stock in the CD cabinet. A second random check did match. The pharmacist subsequently confirmed that she had resolved the mistake and that the rest of the balances matched the physical stock. The pharmacy recorded patient-returned CDs.

The pharmacy had a complaints procedure, but the information governance policy wasn't available. The pharmacist subsequently provided evidence of this. Access to the electronic patient medication record (PMR) was password protected. Confidential paperwork was stored and destroyed securely. Professional indemnity insurance was in place. The pharmacist understood safeguarding requirements and understood how to raise a concern about a vulnerable person. Staff completed training about safeguarding as part of their formal training. There wasn't a safeguarding policy available, but the pharmacist subsequently provided one.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members adequately manage the day-to-day workload within the pharmacy. The team has the range of experience and skills needed to provide its services safely. Team members are supported in their development and can raise concerns if needed.

Inspector's evidence

During the inspection the pharmacy team adequately managed the day-to-day dispensing workload. There was one pharmacist, one trainee pharmacist, one qualified dispenser and a trainee dispenser. The trainee pharmacist had almost completed his year at the pharmacy. He said that he felt he had learnt a lot and developed over the year. The trainee dispenser felt supported and had dedicated training time as part of his registered training course each week. Staff said they had an annual formal appraisal but that they also discussed any issues informally on a daily basis or in the team meetings. The pharmacy team had ad hoc informal training from the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And it has made changes to help keep its team members and people using the pharmacy safe during the pandemic.

Inspector's evidence

The pharmacy was a reasonable size for the services provided. The sign outside was very faded due to the sun and the pharmacist said she was looking to replace it. Inside the pharmacy the public area was neat and tidy. There was suitable heating and lighting. In the dispensary there was hot and cold water available and there were separate areas for the assembly and checking of medicines. A small-sized basic consultation room was available for patients to have a private conversation with pharmacy staff. The pharmacy had processes in place to support safe working during the Covid-19 pandemic. There was a clear plastic screen at the pharmacy counter which provided re-assurance to both the staff and the customers. There was hand sanitiser available. Some of the team still wore face masks but it was optional. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are adequately managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It mainly stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the pharmacy doesn't make a record of action it has taken in response to an alert. This makes it harder for the pharmacy to demonstrate how it has protected people.

Inspector's evidence

The pharmacy had a push-pull door and a very small step at the front door which provided reasonable access for people with a disability or with a pushchair to get into the pharmacy. The pharmacist understood the signposting process and used local knowledge to direct people to local health services. The pharmacy delivered medications to some people. The pharmacist gave a range of advice to people using the pharmacy's services. This included advice when they had a new medicine or if their dose changed. The pharmacist said that she spoke to people who took warfarin to check their INR levels were appropriate and that people taking methotrexate had regular blood tests. But she didn't routinely record the information. The pharmacist knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate.

Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community who needed help managing their medicines and to several care homes. It had processes to make sure people got their medicines in a timely manner. The compliance packs seen recorded the colour and shape of the medicine to make it easier for people to identify the medicine. Patient information leaflets (PILs) were sent each time.

Medicines were stored on shelves in their original containers. Some original packs contained blisters of medicines with different batch numbers and expiry dates. One pack checked had an out-of-date blister in a pack that was still in date. Storing blisters with different expiry dates in one original pack increases the risk that an out-of-date medicine could be supplied. The pharmacist said she would discuss the issue with the team. The pharmacy had a date-checking process and the trainee pharmacist showed the inspector the date-checking records. A check of a small number of stock medicines didn't find any more that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacist could explain the process for managing drug alerts but didn't make a record of the action taken. She said that she would start making a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been tested to make sure they were safe

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.