General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Markand Pharmacy, 122 Henley Road, Caversham, READING, Berkshire, RG4 6DH

Pharmacy reference: 1085264

Type of pharmacy: Community

Date of inspection: 31/01/2024

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is on a parade of local shops and businesses in the Reading suburb of Caversham. It provides a range of services including dispensing prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It provides a selection of other services, including a winter flu vaccination service. And it had registered to deliver the new NHS Pharmacy First Service.

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

The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. The pharmacy has insurance to cover its services. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy has written procedures in place to help ensure that its team members work safely. But it does not do enough to ensure its procedures remain up to date. And it does not do enough to ensure that team members always follow them. The pharmacy adequately completes all the records it needs to by law. But it is not thorough enough in ensuring that all its records are up to date and accurate.

Inspector's evidence

The pharmacy had a system for recording its 'near miss' mistakes and errors. But it was not in regular use. And the pharmacy had not recorded any for some time. The responsible pharmacist (RP) was also the superintendent pharmacist (SP) and owner. And he described how he highlighted and discussed 'near misses' and errors at the time with the team member involved. This helped them to learn from their mistake and prevent it from happening again. The RP was present in the pharmacy full time. And so, he recognised when similar mistakes were being repeated. And when this happened, he reviewed them again with the team, to raise awareness and reduce the risk of a reoccurrence. He was aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to several near miss mistakes with LASAs he had separated several of these products from each other by placing other products in between. He had done this with ramipril tablets and capsules. And pregabalin tablets and capsules. He had also highlighted to the team which people had the less commonly prescribed form of both medicines. He did this so that team members recognised the person's name. This raised their awareness of the patient. And raised their expectation that the less common form of medicine may have been prescribed for them. While it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record what had happened, what its team members had learned or what they would do differently next time. And it did not have a formal review process to identify and manage any trends. The RP, and inspector discussed this and agreed that a more structured approach to recording and reviewing mistakes would help the team to monitor its learning and improvement more effectively. And it would help support team members to include essential checks of their own dispensing before the pharmacist's final accuracy check.

The pharmacy had a set of standard operating procedures (SOPs) to follow. But the SOPs had not had a full and thorough review for several years. The RP was also the superintendent pharmacist (SP) and owner. He recognised the need for a full review of SOPs to ensure that they were relevant ad up to date. Established team members had read the existing SOPs relevant to their roles. Newer team members had been briefed but had not yet read or signed them. The trainee medicines counter assistant (MCA) had worked at the pharmacy for approximately two months. She had come to the role after the pharmacy she worked at previously had closed. The previous pharmacy had provided her with MCA training and DA training which she had yet to complete. The RP hoped that if the trainee's probationary period was successful, he would be able to resume her training. The full time DA had worked alongside the RP, her husband, for many years. The part-time DA had also worked at the pharmacy for several years. And was an established member of the team. Both DAs went about their tasks confidently and it was clear that they understood their work priorities. The DAs consulted the SP

RP when they needed his advice and expertise. And team members asked appropriate questions before handing people's prescription medicines to them. The SP RP displayed his RP notice during the inspection. The RP and inspector discussed the importance of asking appropriate questions when selling a pharmacy (P) medicine. They agreed that this was necessary to ensure that people got the right medicine or treatment. And to ensure the involvement of the pharmacist as appropriate. The notice showed his name and his GPhC registration number as required by law. And it was displayed on the wall in front of the counter where it was visible to people. The SP RP agreed that it was important to ensure that the RP notice was accurate, according to the RP on the day.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that, at times, people were unhappy that their medicines were not available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But the RP had tried to order extra stock of items when he realised there might be a growing problem with availability. And he often did this at a significant cost to the pharmacy where the NHS reimbursement would not match what the pharmacy had paid. He did this to help the people who had been bringing their prescriptions to him for many years. To ensure that they did not run out of their medicines. But he often had to refer people back to their surgeries to obtain an alternative. The pharmacy kept people's preferred brands of medicines in stock when it could. So that people did not have to wait while the team ordered them. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy's private prescription records and RP records were complete and up to date. The pharmacy had an electronic controlled drug (CD) register. And an electronic record for the receipt and destruction of patient-returned CD medicines. The pharmacy maintained running balances of its CDs. And the quantity of a random sample of stock checked by the inspector corresponded to the running balance in the register. The pharmacy's emergency supply records were generally in order. The RP recognised that several of the records needed a clear reason for supply. He also recognised that the pharmacy should ensure that all its essential records are accurate and up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed general training on confidentiality. The pharmacy discarded its paper waste into separate waste containers. And it shredded the waste regularly. Team members kept people's personal information, including their prescription details, out of public view. The SP RP had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. but they knew to report any concerns to the SP RP. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

Inspector's evidence

On the day of the inspection the RP worked with the two DAs and the new trainee MCA. The pharmacy employed a further part-time trainee MCA. This trainee MCA had received in-house training. But she had not yet begun any formal training on a recognised MCA training programme. The RP agreed that all team members should have the right skills for their roles, and that the trainee would be enrolled on an appropriate training course as soon as possible. The RP had recently employed a locum pharmacist to work alongside him twice a week. This allowed the RP to catch up on other tasks. And deliver the pharmacy's other services while the locum managed the prescription service. The pharmacy's prescription numbers had increased in recent months due to the closure of three local pharmacies. And team members worked hard to keep on top of their tasks. And to get people's prescriptions ready on time. The part-time DA described how she and her colleagues had discussed how best to manage the volumes of electronic prescriptions they received each day. They noticed that its local surgeries tended to release most of their electronic repeat prescriptions late in the afternoon. And so, the team decided that it would be best to access the prescription 'spine' and download most prescriptions towards the end of the day. This allowed them to produce labels and order stock first thing the next morning. And with two stock deliveries each day, this meant that most people's prescriptions could be completed that day.

The DAs had discussed the best way to manage their dispensing tasks. And they agreed to vary their tasks each day. They did this to ensure that they remained focused and alert. Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it tried hard to keep on top of its other tasks. The RP and DAs assisted each other. And the trainee MCA when needed. And together they dealt with queries promptly. Team members did not have formal meetings or appraisals about their work performance. But they discussed issues as they worked. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP if they needed to. This was a family run independent pharmacy. And pharmacists felt they could make day-to-day professional decisions in the interest of patients.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was on a local parade of shops and businesses. It had a large retail area with seating for waiting customers. The pharmacy had a medicines counter which supported a transparent screen to help reduce the risk of spreading viral infections. The pharmacy kept its pharmacy medicines behind the counter. The counter was divided in two by a pillar. Which separated the general counter area from a smaller prescription counter. The prescription counter provided a discrete area for people to hand in or receive their prescriptions. The pharmacy had an open area next to the counter which provided access to the dispensary. And a small sales area where the consultation room was located. The consultation room door was kept closed. And it provided a place for people to receive pharmacy services or have a private conversation with the pharmacist.

The pharmacy had a relatively spacious dispensary, with two prescription storage areas. It had enough space for team members to dispense prescriptions including the pharmacy’s multi-compartment compliance packs. It had dispensing worksurfaces on three sides and on a central island. These were all used for the pharmacy’s dispensing activities. And it had storage facilities above and below the worksurfaces. One of the dispensary’s workstations faced the retail space and the back of the medicines counter, so that team members could see people waiting. The pharmacy had a cleaning routine. And it generally kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members cleaned floors periodically and they tried to keep them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy had staff facilities and a staff room. It also had a stock storage room which provided a substantial storage area for excess stock.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had a doorway which provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. But it had minimal information on its windows promoting its services. Posters were generally about non pharmacy services and they appeared to have been there for some time. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care environments. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The DA processed the prescriptions for the compliance packs. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so, people may not have all the necessary information about their medicines to help them to take their medicines properly. The inspector and the team agreed that it was important to ensure that people had all the information they needed about their medicines. The RP gave people advice on a range of matters. And they would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, one of whom was in the at-risk group. The RP had counselled them when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also provided warning cards and information leaflets with each supply. And he was aware of recent changes in the law about supplying valproate medicines in their original packs. The pharmacy offered a community pharmacist consultation service (CPCS). This allowed people to access medicines when they had run out. The pharmacy received referrals from NHS 111 and local GP surgeries for the service. And he often supplied medicines at a cost to the pharmacy. This was when a small quantity was prescribed in an emergency for a medicine which he could not use the remaining split-pack quantity. And so had to discard it. The pharmacist kept appropriate records of each supply.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. But some medicines had been placed back on shelves as loose strips. And not in the manufacturer's original pack. This meant that they were not stored in packs containing all the required manufacturer's information. And while this did not present a high risk of error, it may mean that the

strips could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing. The pharmacy checked the expiry dates of its stock, regularly. And while it did not keep records, team members knew what had been checked. The inspector discussed this with them. And they agreed that by keeping records of what areas of stock had been checked and when, the team could monitor the pharmacy's entire stock for expiry dates more effectively. When the team identified any short-dated items it highlighted them. And it only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its main fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy had a smaller second fridge. And while the RP checked the current temperature periodically, he did not read and record its temperature range day-to-day. During the inspection, the pharmacy set up a system for recording temperatures for the second fridge. And the RP agreed to record and monitor its temperatures daily. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view.

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.