General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Avicenna Pharmacy, 70 Coggeshall Road, BRAINTREE, Essex, CM7 9BY

Pharmacy reference: 1030942

Type of pharmacy: Community

Date of inspection: 05/10/2022

Pharmacy context

The pharmacy is on a main road in a largely residential area near Braintree town centre. It provides a range of services, including the New Medicine Service, flu vaccination service and COVID vaccination service. And it also provides medicines as part of the Community Pharmacist Consultation Service. It receives most of its prescriptions electronically. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people.

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 to help provide them safely. Team members learn from mistakes that happen during the dispensing process to help make the pharmacy's services safer. People can give the pharmacy feedback about its services. The pharmacy keeps its records up to date and accurate. Team members know what to do to help protect vulnerable people. And the pharmacy largely protects people's personal information.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. It had up-to-date standard operating procedures (SOPs), and it reported and reviewed any dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Team members were responsible for recording their own near misses on a paper record in the pharmacy, and these were then recorded on the pharmacy's online reporting system. The pharmacy's head office reviewed the near miss records from all pharmacies within the company. The outcomes from the reviews were discussed openly in the pharmacy. And there was shared learning across the company. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the shelf edges where these medicines were kept were highlighted. Information about these medicines was attached to the shelves, so that team members had to move it to access the medicines behind. This had helped team members pay better attention when selecting these medicines. Team members could not recall any recent changes to the layout of the medicines as a result of near misses. But they did mention about how they would let the whole team know about any medicines which were in similar packaging to another one in the pharmacy at the time it was received from the supplier. Dispensing errors, where a dispensing mistake had reached a person, were recorded on the pharmacy's online reporting system. The pharmacy was not aware about any recent dispensing errors.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. 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.

Team members' roles and responsibilities were specified in the SOPs. Team members explained that the pharmacy would not open if the pharmacist had not turned up in the morning. They knew which tasks should not be carried out if there was no responsible pharmacist (RP) signed in. And knew which tasks should not be undertaken if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were completed correctly. And the nature of the emergency was recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers

examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the relevant registers. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Some people's personal information on bagged items waiting collection could potentially be viewed by people using the pharmacy. The pharmacist said that he would review this and would look to move the barrier forward to restrict access to that area.

The pharmacy had carried out patient satisfaction surveys before the start of the pandemic, but it had not carried one out since. The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. Team members said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office and there were procedures available for them to follow if needed. One of the dispensers knew which people might be classed as vulnerable and said that she would refer to the pharmacist if she had any concerns about them. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. There were contact details displayed in the dispensary 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. And the team works well together to ensure that the workload is well managed. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they can usually do the training at work. They can raise any concerns or make suggestions. And team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, four trained dispensers and one trained medicines counter assistant (MCA) working during the inspection. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. Team members were allocated specific tasks that they completed on certain days to ensure that the workload was managed well and all tasks were completed when needed. And they covered for each other when needed.

The MCA appeared confident when speaking with people and she was aware of the restrictions on sales of products containing pseudoephedrine. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she used effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He had recently undertaken some training about the new Covid vaccine. And he had completed some online training about the flu vaccination service. He said that he spoke with the local surgeries about the flu vaccination service as both were offering the service and this was to ensure that there was no overlap. He also mentioned that he had recently completed a clinical diploma. And he felt able to take professional decisions. He had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members were provided with ongoing training on a regular basis. One of the dispensers explained that team members usually had time to complete the modules at work during quieter times, but they could also access them at home. And the pharmacist monitored the team’s training to ensure that it was completed in a timely manner. The team also had regular reviews of any dispensing mistakes and discussed these openly.

One of the dispensers explained that prior to the pandemic, team members had annual appraisals and performance reviews. And these were due to start again soon. 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. 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.

There were four chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacy's main consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. It dispenses medicines into multi-compartment compliance packs safely. And it gets its medicines from reputable suppliers and stores them properly. The pharmacy responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power-assisted 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. The pharmacy could produce large print labels for people who needed them. The pharmacy managed its Covid vaccination service with a pre-booked appointment system. And the flu vaccination service was on a 'walk-in' basis, but the pharmacist said that he would signpost people to another vaccination centre if the pharmacy was too busy to provide the service.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept on the patient's medication record. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity for the pharmacist to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted and the date the prescription was due to expire was recorded on the top of the prescription. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that CDs and fridge items were checked with people when handing them out. The pharmacy supplied valproate medicines to a few people. One of the dispensers said that there were no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information booklets, warning cards and warning labels available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. And items due to expire within the next three months were marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And these were annotated with the dates the order had been hastened with the suppliers to show that this had been done. Uncollected prescriptions were checked monthly and any items remaining uncollected after around two months were returned to dispensing stock. And the prescriptions for these items were returned to the NHS electronic system or to the prescriber. Team members said that people would be contacted before their prescriptions were returned.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. One of the dispensers said that the pharmacy did not manage the prescriptions for most people who had their medicines in these packs, but it did ordered prescriptions for some people who needed this done. Managed prescriptions were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. One of the dispensers said that people usually ordered these from their GP 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. Team members wore gloves when handling medicines that were placed in these packs.

CDs were 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 segregated. Returned CDs were recorded in a register and destroyed with a witness, and two people's names were recorded electronically.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures for most deliveries to help minimise the spread of infection. But it did obtain people's signatures for some deliveries and these were recorded in a way so that other people's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier 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

There were up-to-date reference sources in the pharmacy and these could also be accessed online. One of the dispensers said that the blood pressure monitor had been in use for less than a year. And this would be replaced by the pharmacy’s head office in in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Suitable equipment for measuring liquids was available. Separate liquid measures were used to measure certain liquids only. Triangle tablet counters were available and clean. 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. The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily with the maximum and minimum temperatures routinely recorded. Records indicated that the temperatures were consistently within the recommended range.

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.