General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 201 Rayleigh Road, Hutton, BRENTWOOD, Essex, CM13 1LZ

Pharmacy reference: 1030966

Type of pharmacy: Community

Date of inspection: 19/03/2024

Pharmacy context

The pharmacy is on a small parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and blood pressure checks. And it provides contraceptives and pneumonia vaccinations using patient group directions. The pharmacy 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 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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
2. Staff	Standards met	2.2	Good practice	Team members undertake structured ongoing training to help keep their knowledge and skills up to date. And they get time set aside to complete it.
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 identifies and manages the risks associated with its services to help provide them safely. And it learns from mistakes that happen during the dispensing process to help make its services safer. People can feed back about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy protects people's personal information. And it largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. The dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And she knew which tasks should not be undertaken if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. Workspace in the dispensary was free from clutter. And there was an organised workflow which helped staff to prioritise tasks and manage the workload.

The pharmacist explained how the team dealt with dispensing mistakes that were identified before the medicine had reached a person (near misses). The near miss was highlighted with the team member involved at the time of the incident. And the team member was then responsible for identifying and rectifying their own mistake. Near misses were recorded and reviewed regularly for any patterns. The outcomes from the reviews were discussed openly during the regular team meetings. And learning points were shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that following a recent review, it was noticed that most of the near misses involved the incorrect quantity of a medicine being dispensed. Team members were reminded to not rush and check their work before passing it to the pharmacist to be checked. The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. She explained that any dispensing incidents were recorded electronically, the pharmacy's head office informed, and a root cause analysis undertaken.

The pharmacy had current professional indemnity insurance. The private prescription records were completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any liquid overage was recorded in the register. 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. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The pharmacist said that she would ensure that this information was recorded in future.

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. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about how people could complaint were available in the shop area and on the pharmacy's website. The pharmacist said that there had not been any recent complaints.

Team members had undertaken training about safeguarding vulnerable people. The delivery driver described potential signs that might indicate a safeguarding concern and he said that he would refer any concerns to the pharmacist. The pharmacist gave an example of action the pharmacy had taken in response to a recent safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. And team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one trained dispenser and one trainee medicines counter assistant (MCA) working during the inspection. The trainee MCA had started working at the pharmacy on the day of the inspection. The pharmacist confirmed that he would be enrolled on an accredited course for his role within the required timeframe. The dispenser 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. And the pharmacist said that there were contingency arrangements for pharmacist cover if needed. 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. The pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. The dispenser said 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 was aware of the restrictions on sales medicines containing pseudoephedrine. She asked people relevant questions to establish whether the medicines were suitable for the person. The trainee MCA referred to the dispenser and pharmacist throughout the inspection when needed.

Team members had to complete mandatory training which included reading SOP updates. And they could also access online training modules to increase or refresh their knowledge. The pharmacist said that team members had recently completed some refresher training about the dispensing process for CDs. They had also undergone some training for the Pharmacy Quality Scheme, the Pharmacy First service and blood pressure training. The pharmacist monitored training and said that team members had set time each week to complete training at work. The pharmacist was of the continuing professional development requirement for professional revalidation. She had recently completed additional training for otitis media diagnosis. And she felt able to make professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. Training was monitored by the pharmacist and area manager. Pharmacy-related magazines and pass on to team.

Team members said that information was usually passed on informally during the day. There were weekly team meetings to share any information received from the pharmacy's head office and discuss any issues. The pharmacist said that the pharmacy attended weekly conference calls and there was a yearly face-to-face meeting with the area manager. During the meetings they discussed the PQS, targets and any issues. The pharmacy received charts and tables to show where the pharmacy targets were in relation to other pharmacies in the group. And it received tasks via the online portal which required action to be taken and the task tracker updated to reflect this. The pharmacist talked about a

recent task about the reclassification of codeine linctus. The task had been actioned and all team members had been informed about the change. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had yearly performance reviews with the pharmacist and the pharmacist had theirs with the area manager.

Targets were set for the New Medicine Service (NMS) and the Pharmacy First service. The pharmacist said that she had made the local surgery aware that the pharmacy was offering the Pharmacy First service. She felt a certain amount of pressure to achieve the targets, but she felt supported by the area manager and additional cover was provided where needed. She would not let the targets affect her professional judgement. And she provided the services for the benefit of the people using the pharmacy.

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 this presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. 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.

There were some chairs in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users, and it was in the shop area. It was suitably equipped, well-screened and 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. And there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. And the pharmacy ensures that people receiving their medicines in multi-compartment compliance packs have the additional information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and it stores them properly. It responds appropriately to drug alerts and product recalls. And people with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. 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 in the shop area. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels for people that needed them.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of relevant blood test results was usually kept on the patient's medication record. Prescriptions for Schedule 3 and 4 CDs were highlighted, and 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 she carried an additional check on dispensed CDs before they were handed out to people. And CDs and fridge items were checked with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). She said that she would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacist explained how the pharmacy managed NHS 111 referrals and described a time that a supply had not been made because it was not appropriate.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items with a short expiry date were clearly marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and

two signatures were recorded. Denaturing kits were available for the safe destruction of CDs.

The pharmacist said that the bar codes on bagged items waiting collection were scanned twice a week and people were sent a text message reminder to notify them that they prescription was ready to collect. She explained that the pharmacy obtained consent from people for this service. Items remaining uncollected after around four weeks were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber. Part-dispensed prescriptions were checked daily. '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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy had created a barcode for the box where the part-dispensed prescriptions were kept. This meant that it was easier for team members to locate these prescriptions when needed.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacist said that people usually contacted the pharmacy if they did not need their 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it 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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded on a hand-held electronic device. All undelivered medicines were returned to the pharmacy before the pharmacy closed. When the person was not at home, a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

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. A separate counter was marked for cytotoxic use only which 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 phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had up-to-date reference sources available in the pharmacy and online. The blood pressure monitor was replaced in line with the manufacturer’s guidance and the weighing scales appeared to be in good working order.

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.