

# Registered pharmacy inspection report

**Pharmacy Name:** Shadforth;M.W., 49 High Street, BILLERICAY, Essex, CM12 9AX

**Pharmacy reference:** 1030975

**Type of pharmacy:** Community

**Date of inspection:** 04/10/2022

## Pharmacy context

The pharmacy is located on a busy high street in a residential area. It is part of a small group of pharmacies based in Essex. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to some people who need help managing their medicines. The pharmacy also provides flu vaccinations and the New Medicine Service (NMS). It supplies warfarin to people and carries out private Covid testing.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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
<b>1. Governance</b>	Standards met	1.2	Good practice	Members of the pharmacy team review things that go wrong to identify learning. And they take action to help stop similar mistakes happening again.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are safe and effective. The pharmacy keeps the records it needs to by law so that medicines are supplied safely and legally. People who use the pharmacy can give feedback on its services. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process.

### Inspector's evidence

Standard operating procedures (SOPs) were available. These were reviewed and sent from head office. The team were able to make local variations and had made changes to the way in which printed and labelled prescriptions were organised. Team members read SOPs and signed them. The team had been routinely ensuring infection control measures were in place and all team members were using personal protective equipment.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and where the medicine was handed to a person (dispensing errors). Team members had individual books to record their near misses, team members recorded their own mistakes. At the end of each month individuals near misses were reviewed by the pharmacy manager. A review of all the near misses was also carried out with the monthly report forwarded on to the company's head office. An annual report was also completed. Each morning the team had a huddle as part of which near misses and errors from the previous day were discussed. As a result of past reviews sertraline and sildenafil were separated on the shelves and warnings were stuck on the shelf edges for medicines which looked or sounded alike. One of the team members gave an example of separating the different formulations of Symbicort inhalers into separate drawers and put into separate drawers. Dispensing errors were recorded. The pharmacy had a book with blank incident report forms which were used. A copy was retained in the pharmacy and a copy was sent to head office. As a result of past errors, the team had separated medicines on the shelves, tidied shelves, and retrained team members.

A correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. The pharmacy manager tried and resolved any issues in store and also passed on details to the head office. As a result of feedback, the text messaging service had been introduced so that people would be notified of when their prescription was ready and would only come in to collect after.

Records for private prescriptions, emergency supplies, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were well maintained. Controlled drugs (CDs) that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register. CD balance checks were carried out regularly.

Assembled prescriptions were stored in the dispensary and behind the medicines counter and people's private information was not visible to others using the pharmacy. An information governance policy was available. Confidential paperwork and dispensing labels were segregated and sent to the pharmacy's head office for shredding. Team members who accessed NHS systems had smartcards. Summary Care Records (SCRs) could be accessed by the RP and pharmacy manager. Consent was gained

verbally from people and in some cases written confirmation was also gained.

The pharmacy manager and pharmacist had completed level two safeguarding training and most team members had completed level one training. Details for the local safeguarding contacts were available.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date.

### Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, who was a locum pharmacist. An accuracy checking technician (ACT) who was also the pharmacy manager, a trained dispenser, two trainee dispensers and two trained medicines counter assistants (MCA). The pharmacy manager felt there were enough staff and an additional dispenser had been recruited who was due to start the following week. The pharmacy had not had a regular store-based pharmacist for a while.

Individual performance and development were managed informally by the pharmacy manager. Team members were provided with feedback and encouragement. The pharmacy manager had one to one chats with team members and spoke to them privately when needed. Positive feedback was shared with the team.

The MCA counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. She described handing out prescriptions in line with SOPs and was aware of the validity for prescriptions including those containing CDs. She was aware of the maximum quantities of certain medicines which could be sold over the counter.

To keep up to date team members used the daily huddles to discuss seasonal conditions. Two of the team members helped to train colleagues. The manager tried to provide team members with set-aside time to complete their formal training, the company had a relief team who would come in to allow colleagues to complete their training. However, in some cases training had to be done in the team member's own time. Information was sent from head office in relation to medicines changing category and update on different products. Team members were required to read and sign this.

Team members discussed issues as they arose. Huddles were held each morning to discuss the tasks that needed to be completed that day, any incidents from the previous day or any information that needed to be shared. Team members described that the head office team were supportive and could be reached via phone. Feedback and suggestions were taken on board. There were no targets for services provided.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide an appropriate environment to deliver its services from. And its premises are suitably clean and secure.

### Inspector's evidence

The pharmacy was bright, clean, and organised. There was ample workspace which was clear of clutter and organised. Workspace had also been roughly allocated for certain tasks. A dedicated space upstairs was used for preparing multi-compartment compliance packs and two separate benches were dedicated for checking prescriptions. A clean sink was available for the preparation of medicines. Cleaning was carried out by team members at regular intervals and a contracted cleaner came in once a week. The pharmacy had a consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. The room was clean. There was a laptop in the room which could be used to access electronic records. The pharmacy manager provided an assurance that she would change the settings to set up a lock screen after a few minutes of inactivity. The room temperature and lighting were adequate for the provision of pharmacy services and the safe storage of medicines. The premises were secure from unauthorised access.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from reputable sources and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

### Inspector's evidence

The pharmacy was easily accessible, there was a flat entrance from the street. Aisles were wide and allowed easy access to the medicines counter. Services were appropriately advertised to patients and team members knew of other services which were available locally and described signposting people to these where needed. A delivery service was offered to those people who were unable to access the pharmacy and the pharmacy were also able to produce large print labels.

The pharmacy manager felt the flu vaccination service had the most impact on the local population. She described that as this year the pharmacy did not have a regular pharmacist, they were only providing vaccinations on a walk-in basis when an accredited pharmacist was working or if the team were aware that a trained pharmacist was working on a particular day, they called people to book them in.

The pharmacy had an established workflow in place. The workstation at the front was dedicated for dispensing prescriptions for people who were waiting or were due to call back after handing in their prescription. Once dispensed these were checked by the pharmacist and handed out. Other prescriptions were printed and labelled and arranged alphabetically. Dispensers worked through dispensing these. There was a dedicated area for storing prescriptions which were incomplete and another area for storing prescriptions which were waiting to be checked. The ACT checked repeat prescriptions along with the RP. Prescriptions were clinically checked by the RP and the prescription form was stamped and initialled once checked by the pharmacist. Dispensed and checked-by boxes were available on labels and prescription forms were stamped with a quad stamp and these were routinely used. Colour-coded baskets were used to separate prescriptions, preventing transfer of items between people and to manage the workflow.

The RP was not fully aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. He was informed by the inspector and provided assurance that he would read up on the guidance. Team members described in most cases sodium valproate was dispensed in its original pack. Spare warning labels were also available. When sodium valproate was not dispensed in its original pack was discussed. The labelling system also printed a drug safety alert when sodium valproate was labelled, team members stuck this label onto the prescription form. Additional checks were carried out when people collected medicines which required ongoing monitoring. The pharmacy provided a warfarin supply service to people residing in Basildon and Billericay. In most cases people had their INR monitored at Basildon hospital and brought in their records. The pharmacist checked these and then supplied the appropriate strength of warfarin required. A record of this was made.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy used trackers to manage the service and keep a record of when prescriptions were due and had to be

ordered. Prescriptions were ordered by the pharmacy, once received they were checked for any missing items or changes and processed. These were queried with the surgery and a note was made. There were individual record charts for each person on the service, this had a record of all their medicines, the dosage and which compartment it went in. The sheet also had a section to record when packs were prepared. New sheets were prepared in the event that there were any changes. Once the prescription was processed, one of the team members picked the stock and prepared the packs. A record was made of the date each of the medicines expired. Prepared packs were checked up the pharmacists and sealed. There were four packs prepared earlier on the day of the inspection, the team member did not think they would be checked and sealed on that day. She provided an assurance that this was uncommon and that she would seal the pack before it was checked. There were no assembled packs available. The dispenser described how she labelled packs and showed a sample of a backing sheet on the system. Packs were labelled with product descriptions and mandatory warnings, and patient information leaflets (PILs) were supplied monthly. The expiry date of all medicines was also recorded on the backing sheet.

The pharmacy provided a delivery service. Signatures were no longer obtained when medicines were delivered and this was to help infection control. The driver made a record of the date and time of delivery as well who had accepted the delivery. Delivery logs were kept in the pharmacy. In the event that someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperatures were within the required range for the storage of medicines. CDs were held securely.

Expiry-date checks were carried out four times a year. Short-dated medicines were marked with labels and annotated with the month they were due to expire. These were also recorded on a log so that they could be removed from the shelves easily. Team members were allocated sections they were responsible for and a date checking matrix was available. No date-expired medicines were found on the shelves checked. Out- of-date and other waste medicines were kept separate from stock and generally stored securely until collected by licensed waste collectors. Drug recalls were received via email and these were usually checked by the manager. Once the alert had been actioned a record was made.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy had a range of clean glass calibrated measures available. Tablet counting trays were available. Up-to-date reference sources were available including access to the internet. The pharmacy had a fridge of adequate size. A blood pressure monitor was available which was used as part of the services offered. This was sent to the head office for calibration. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✔</span> <b>Excellent practice</b>	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.
<span style="color: green;">✔</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✔</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.