General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cross Chemists, 133 London Road, Great Tarpots, BENFLEET, Essex, SS7 5UH

Pharmacy reference: 1030986

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

The pharmacy is located on a parade of shops on a busy main road. It is surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 85% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, a stop smoking service, the NHS Urgent Medicine Supply Advance Service and influenza vaccinations. And it supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. One of the pharmacists is an independent prescriber.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It 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. It regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely. And it largely protects people's personal information.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Cardboard dividers were sometimes used to separate medicines and some shelf edges had been highlighted. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The pharmacist confirmed that the incident had been reported to the National Pharmacy Association (NPA) and been recorded on the National Reporting and Learning System. The NPA shared learnings from incidents with different organisations.

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. The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. She confirmed that she would accept prescriptions from people, but she would not sell any medicines or hand out dispensed items. The dispenser said that she would not carry out any dispensing tasks until the pharmacist was in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed. There were signed in-date Patient Group Directions available for the relevant services offered. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were mostly completed correctly, but there were several private prescriptions that did not have the required information on them when the supply was made. And the prescriber's details were not always recorded on the private prescription record. This could make it harder for the pharmacy to find these details if there was a future query. 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. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that she would ensure that this information was recorded in future. Controlled drug (CD) registers examined were mostly filled in correctly, and the CD running balances were checked at regular intervals. But the address of the supplier was not usually recorded in the registers. The pharmacist said that she would record this in future. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

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 pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive and 100% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed. The pharmacist said that the pharmacy had recently received a complaint and the superintendent had been dealing with it.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed some safeguarding training either provided by the pharmacy or with previous employers. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. The team discusses adverse incidents and uses these to learn and improve. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The 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, two trained dispensers, one trained MCA and one sales assistant working in the pharmacy on the day of the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. 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. She explained about a peer discussion she had recently had with a geriatric specialist consultant about medicines use in older people. She was taking part in the Care Homes Independent Pharmacist Prescribing Study to enhance her knowledge which would allow her to better serve the local population. She had regular meetings with the local GP's to discuss any issues or concerns. And said that she had a good working relationship with the local surgeries and informed them when she had prescribed a medicine for one of their patients. She confirmed that she specialised in ear, nose and throat, and minor ailments. And she explained that she only prescribed medicines that were within her professional scope.

Team members had completed accredited training for their role. The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. She said that she kept up to date with any changes and read pharmacy magazines. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacist said that the superintendent pharmacist held team meetings when needed to ensure that important information was passed on to all team members. She explained that a team meeting had been held to discuss a recent dispensing incident. Team members confirmed that they felt comfortable about discussing any issues or concerns with the pharmacist, and they could make suggestions. The dispenser said that she had not had a formal appraisal or performance review since starting at the pharmacy around six months ago, but she had been given ongoing feedback about her performance.

Targets were not set for team members. The pharmacist said that she provided the services for the benefit of the people who used the pharmacy. But she did encourage team members to identify people who may benefit from a Medicines Use Review or the New Medicines Service.

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; this 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; the room temperature was suitable for storing medicines.

There were two 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. Some medicines were not kept securely, and some people’s personal details were potentially visible on some items in an area of the pharmacy. The pharmacist said that she would arrange for a barrier to be installed to further restrict access to this area.

The consultation room was accessible to wheelchair users and was located at the rear of the pharmacy. It could be accessed from the shop area and the dispensary. It was suitably equipped but not kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The large window in the door to the dispensary was see-through. The pharmacist said that she would arrange for this to be covered.

The kitchen area and 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

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

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.

The pharmacist said that the pharmacy did not routinely check the blood test results for people taking higher-risk medicines such as warfarin and methotrexate. 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 not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were kept with dispensed items until they were collected. There were none found waiting collection. The MCA knew that these were only valid for 28 days and she confirmed that these were highlighted. 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. The pharmacy did not have the relevant patient information leaflets or warning cards available. A white dispensing box containing valproic acid tablets was found with dispensing stock. This had been labelled for a person and not collected, but it did not have the necessary warning sticker attached. The pharmacist said that she would order replacement stickers from the manufacturer and ensure that the packaging was suitably labelled when supplied to people.

Stock was stored in an organised manner in the dispensary. The dispenser said that she planned to implement a more reliable date checking system and keep a record of when areas had been checked. Stock due to expire within the next few months was marked. There were some medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. The pharmacist disposed of the medicines appropriately and confirmed that she would inform team members to keep medicines in their original packaging in future. This would make it easier for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

Part-dispensed prescriptions were checked daily. 'Owings' notes were usually 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. Uncollected prescriptions were checked monthly. If the person had not collected their items after two months, the prescription was returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where

possible. The pharmacy did not always keep the prescription for dispensed medicines. This could increase the chance of them being handed out when the prescription is no longer valid. The pharmacist said that she would ensure that prescriptions were kept with dispensed items until they were collected.

The pharmacist said that assessments were carried out for the people who received their medicines in multi-compartment compliance packs to show that the service was needed. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed them. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the people contacted the pharmacy when they needed them with their packs. 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. Detailed medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored securely. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. There were some Schedule 3 CDs found in the pharmaceutical medicines waste bins. The inspector reminded the pharmacist that these would need to be denatured before being disposed of. The pharmacist said that returned CDs were recorded in a register and destroyed with a witness, and that two signatures were recorded. But the book could not be located during the inspection.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person'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. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The MCA said that the superintendent pharmacist was in the process of implementing the system fully. She confirmed that she had undertaken some training on how the system worked. The pharmacist said that she would ask the regular pharmacist about whether there were any written procedures were available.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely 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 but not for volumes less than ten millilitres. The pharmacist said that she used a plastic oral syringe to measure small amounts. She confirmed that she would order a suitable measure. Tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for around one year. The carbon monoxide testing machine was calibrated by an outside agency and the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; 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.

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.