General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** West Bergholt Pharmacy, 39 Chapel Road, West Bergholt, COLCHESTER, Essex, CO6 3JB

**Pharmacy reference:** 1031105

**Type of pharmacy:** Community

**Date of inspection:** 06/10/2022

## Pharmacy context

The pharmacy is in a largely residential area. It provides a range of services, including the New Medicine Service, the COVID vaccination service and flu vaccination service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. It receives most of its prescriptions electronically.

## 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 |
|---|---|---|---|---|
| **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. People can feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. They record their dispensing mistakes so that they can learn and make the services safer. The pharmacy largely keeps its records up to date and accurate. And it mostly protects people's personal information well.

### 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), and reporting and reviewing of dispensing mistakes. Some team members had signed to show that they had read, understood, and agreed to follow the SOPs. And others were in the process of reading them and would sign once they had understood the procedures. 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. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The responsible pharmacist (RP) said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person.

Workspace in the dispensary was a little cluttered but there was clear space to dispense and check medicines. And there was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to help minimise the risk of medicines being transferred to a different prescription. And 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 RP said that the pharmacy would not open if the pharmacist had not turned up in the morning. And the pharmacy closed at lunch time. Team members knew which tasks they should not carry out if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was completed correctly. The pharmacy had signed in-date patient group directions available for the relevant services. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. But the recorded quantity of one CD item checked at random was not the same as the physical amount of stock available. The pharmacist said that he would attempt reconcile this and report to the Controlled Drugs Accountable Officer if needed. The pharmacy's private prescription records were mostly completed correctly, but the correct prescriber details and date on prescription was not always recorded. And 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 he would ensure that the private prescription record and emergency supply record were completed fully and correctly in future.

Confidential waste was removed by a 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 bags of dispensed medicines were not kept securely. And some people's personal details were potentially visible on them. This was discussed with the RP during the inspection and these were moved to a more suitable place in the pharmacy.

The pharmacy had not carried out a patient satisfaction survey since the start of the pandemic. The complaints procedure was available for team members to follow if needed. The RP said that there had not been any recent complaints.

The pharmacists had completed the necessary training about protecting vulnerable people. One of the trainee dispensers had done some online safeguarding training at the pharmacy. She described which people might be classed as vulnerable and said that she would refer any concerns to the pharmacist. There had not been any safeguarding concerns at the pharmacy. And 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 do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular informal meetings. Team members can take professional decisions to ensure people taking medicines are safe.

### Inspector's evidence

There were three pharmacists (one was the owner and he was the RP on the day of the inspection), two trainee dispensers and one trainee medicines counter assistant (MCA) working during the inspection. One of the pharmacists was administering the COVID vaccines and the other two were working in the dispensary. The RP explained that he had already applied for accredited courses for two of the trainee dispensers employed at the pharmacy.

The team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The trainee MCA appeared confident when speaking with people. She had only worked at the pharmacy for a few days and wrote people's names and requests down to ensure that the messages were passed on correctly to the relevant team member. 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 asked relevant questions to establish whether the medicines were suitable for the person. She referred through the inspection to other team members. She said that she had previously worked in a customer service role and this showed in the way that she dealt with people.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. Some recent training that they had undertaken included the updated COVID vaccination training and online dermatology training. The RP said that team members were not provided with ongoing training on a regular basis, but they did receive some. He passed on important information to team members and the pharmacy had access to pharmacy-related articles. The pharmacists felt able to take professional decisions. And two of them had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The RP said that there were regular informal meetings so that the team could discuss any issues and tasks could be allocated. The team were part of a messaging group so that team members not present could be made aware about any issues or receive information promptly. Team members underwent ongoing information appraisals and performance reviews. They could discuss any issues with other team members when they arose. 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 generally tidy. 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. Pharmacy-only medicines were kept behind the counter. Air conditioning was available and the room temperature was suitable for storing medicines.

There were two chairs in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users and was located to the rear of the shop area. It was suitably equipped and well-screened. The room was being used to carry out the COVID vaccination service during the inspection. Conversations at a normal level of volume in the consultation room could not be heard from the shop area when the door was closed. 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. And overall, the pharmacy provides its services safely and manages them appropriately. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. And it responds appropriately to drug alerts and product recalls. 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. An alarm sounded when the door was opened which alerted team members. 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 if needed. There was a notice at the entrance to the pharmacy directing people to either the dispensary or to the consultation room for their COVID vaccination. People formed two queues, but sometimes people had joined the wrong queue as the notice at the entrance was sometimes obscured by people. The team said that they would consider moving the notice to a more prominent position. The COVID vaccination service had originally been provided at the local village hall but it had recently been moved to in the pharmacy as the demand had reduced. The RP explained that the pharmacy only offered the service when it had stock of the vaccines and opened up the appointment system according to this. The RP was also trained to offer the COVID vaccination service and could provide cover if needed. And he was the clinical lead for the service.

The RP said that he usually handed out higher-risk medicines such as methotrexate and warfarin to people. This gave him the opportunity to speak with these people and check that they were having the relevant blood tests done at appropriate intervals. But prescriptions for higher-risk medicines were not always highlighted. So, if other team members were handing these medicines out it could be harder for them to know if people required additional information. Prescriptions for Schedule 3 and 4 CDs were not routinely highlighted. And one of the trainee dispensers did not know which prescriptions were only valid for 28 days. This could increase the chance of these medicines being supplied when the prescription was no longer valid. There were several bagged items waiting collection and the prescription for them was no longer valid. These were given to a team member and the inspector discussed these with the RP. The RP said that he would implement a more reliable system to help minimise the chance of medicines being supplied without a valid prescription. 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 had the relevant patient information leaflets, warning cards available and warning stickers available. And team members were aware of the warnings that must be given to people when these medicines were supplied.

Stock was stored in an organised manner in the dispensary. The pharmacist said that he checked expiry dates for stock items 'as and when he had time'. Items with a short expiry were not highlighted and a few medicines with dispensing stock were found in containers which did not have all the required information on such as batch number or expiry date. There was one box which contained mixed batches found with dispensing stock. Not keeping the medicines in appropriately labelled containers

could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The inspector discussed this with one of the trainee dispensers and the RP during the inspection. They provided assurances that a more reliable date-checking routine would be implemented and medicines would be kept in their original packaging in future.

Part-dispensed prescriptions were checked frequently. Prescriptions for alternate medicines were requested from prescribers where needed. And 'owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked around once a month. And items were returned to dispensing stock after around two months if they had not been collected. Prescriptions for these items were returned to the NHS electronic system or to the prescriber.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs 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 by the pharmacy. The pharmacist said that people contacted their GP surgery 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.

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 signatures were recorded.

The pharmacist said that the fridge temperatures were checked daily, but these were not always recorded. The current temperatures were within the recommended range. And the fridges were suitable for storing medicines and were not overstocked. The RP said that he would ensure that the temperatures were recorded in future.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. A copy of the delivery sheet was kept in the pharmacy so that the team could let people know if their medicines were out for delivery if they asked. All undelivered medicines were returned to the pharmacy before the end of the working day. And if a person was not at home when the delivery attempt was made, 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 RP explained the action the pharmacy took in response to any alerts or recalls. But no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he used to keep a record and would start doing this again.

## 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 the 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.

Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

## 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. |