General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chemicrest Pharmacy, 39/41 Spa Road, HOCKLEY, Essex, SS5 4AZ

Pharmacy reference: 1031199

Type of pharmacy: Community

Date of inspection: 08/02/2023

Pharmacy context

The pharmacy is on a parade of shops on a busy high street in a town centre. It provides a range of services, including the New Medicine Service and the flu vaccination service. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy receives most of its prescriptions electronically. And it supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines.

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 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. And it uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information. And it seeks feedback from people who use the pharmacy. It largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. 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 their own mistakes where possible. 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. And the outcomes from the reviews were discussed openly during the regular team meetings. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where a delivery had been taken to the wrong address. The person's address was very similar to the address it was taken to. Following the incident, the address label was now highlighted, and the driver was reminded to check the person's name before handing the items over.

Team members signed 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. Baskets were used to minimise the risk of medicines being transferred to a different prescription. When asked, one of the medicines counter assistants (MCA) explained knew that she would not sell any medicines if there was no responsible pharmacist (RP). And she also knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed, and the RP record was completed correctly. The private prescription records were largely completed correctly, but labels were attached to the book rather than the record being written. The pharmacist said that she would enquire with the superintendent pharmacist (SI) about using the pharmacy's computer system to record the private prescriptions electronically. But in the meantime, she would ensure that the paper records were completed correctly.

Confidential waste was taken to the pharmacy's head office for appropriate disposal. 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. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. And team members had completed training about protecting people's personal information.

The pharmacy was in the process of carrying out a patient satisfaction survey. The pharmacist said that this was the first one that the pharmacy had undertaken since the start of the pandemic. The complaints procedure was available for team members to follow if needed and details about how people could make a complaint were displayed in the shop area. Team members said that there had not been any recent complaints received about the pharmacy.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. 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. One of the dispensers described the types of people who might be classed as vulnerable, and she said that she would refer any concerns to the pharmacist. 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. And the pharmacy ensures that it has the right skill mix to manage its workload effectively. Team members are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they can take professional decisions to ensure people taking medicines are safe. Team members have regular meetings and can raise any concerns or make suggestions.

Inspector's evidence

There was one pharmacist, two trained dispensers and two trained MCAs working during the inspection. The team members wore smart uniforms with name badges displaying their role. And they had completed an accredited course for their role. They worked well together and communicated effectively throughout the inspection to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. One of the MCAs when asked, checked with the pharmacist as to whether she could sell more than one box of pseudoephedrine-containing products. She knew which medicines might be abused or require additional care. And would refer to the pharmacist if a person was regularly requesting to purchase an over-the-counter medicine. She asked questions to establish whether a medicine was suitable for the person it was intended for and referred to the pharmacist if unsure. The 'WWHAM' questions were displayed at the medicines counter for team members to refer to where needed.

Team members explained that they regularly completed online training modules provided by an external company. One of the dispensers had recently been asked to ensure that all team members were up to date with the required training. She said that she would collate team member's training certificates. Team members said that they were allowed time during quieter periods to complete training. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She said that she had recently completed the online refresher training for the flu vaccination service. And she had undertaken some management training to help with the effective running of the pharmacy. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she felt able to make professional decisions.

Team members said that they had a huddle each morning to discuss any issues and allocate tasks. And they discussed any issues throughout out the day as they arose. They had yearly appraisals and performance reviews. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions. The SI visited the pharmacy at regular intervals and the owner of the company visited the pharmacy weekly to discuss any issues. The pharmacist explained that the SI and owner were responsive to requests. She said that she had recently asked to up skill one of the MCA so that they could work in the dispensary. This had helped to ensure that the pharmacy had the right skill mix to manage the workload. And one of the MCAs has been trained to be a vaccinator which had meant that the pharmacist had more time to carry out other services. The pharmacist said that the pharmacy now provided ear consultations after she had requested this. Targets were not set for team members. The pharmacist said that she carried out 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 co-located with e Post Office. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter. And 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 two chairs in the shop area for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacy's consultation at the back of the shop area and it was accessible to wheelchair users. 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

The pharmacy manages its services well and provides them safely. It gets its medicines from reputable suppliers and stores them properly and it responds appropriately to drug alerts and product recalls. 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 with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. And the pharmacy could produce large print labels for those who needed them.

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 the local NHS hospital ensured that people taking these medicines were being correctly monitored before prescriptions were issued. Prescriptions for Schedule 3 CDs were highlighted but Schedule 4 weren't. The pharmacist said that she would highlight these in future to help minimise the chance of these being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members checked CDs and fridge items 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. The pharmacist could not find any additional warning labels, patient information leaflets or warning cards for use with split packs. She said that she would order them from the medicine manufacturer and use with all split packs in future. Team members were not aware that the warning card attached to the packs could be removed to allow space to stick the dispensing labels without covering up any of the important information.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next twelve months were marked. And there were no date-expired medicines found in with dispensing stock. 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. CDs were stored in accordance with legal requirements, and they were kept secure. And the pharmacy had denaturing kits 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 uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items for around a couple of months. Items remaining uncollected were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. The pharmacy used an electronic prescription tracking system to monitor prescriptions which were due to expire so that these were removed from the retrieval system before the prescription had expired. Part-dispensed prescriptions were checked frequently and 'owings' notes were provided when prescriptions could not be dispensed in full. Team

members said that people were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. The pharmacy routinely emailed the GP surgeries if there was a long-term supply issue with a medicine and suggested alternate medicines where available. Follow up emails were routinely sent so that people were not left without medicine unnecessarily. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacist said that she carried out assessments for people who had their medicines in multi-compartment compliance packs to show that they needed the packs. But these assessments were not documented. One of the dispensers explained that 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. Prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The dispenser said that people usually requested these if they needed 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, but patient information leaflets were not routinely supplied. The pharmacist said that these would be supplied 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. The driver signed to show that they had taken CDs for delivery and initialled the delivery list to show that they had delivered the medicines. 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 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

The pharmacy had a variety of suitable equipment for measuring liquids which were clean. And it had clean triangle tablet counters with one 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.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor was replaced 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.

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.