General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Belfairs Pharmacy, 327 Eastwood Road North, LEIGH-ON-SEA, Essex, SS9 4LT

Pharmacy reference: 1031297

Type of pharmacy: Community

Date of inspection: 15/08/2022

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides a range of services, including the New Medicine Service, Covid vaccinations, stop smoking, BP checks and emergency hormonal contraception. It also provides medicines as part of the Community Pharmacist Consultation Service. And it receives most of its prescriptions electronically. The pharmacy supplies medications in multi-compartment compliance packs to large number people who live in their own homes to help them manage their medicines. 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	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 adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy generally keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. There was a set of up-to-date standard operating procedures (SOPs) available and team members had signed to show that they had read, understood, and agreed to follow the SOPs. 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. Team members explained that they were responsible for identifying and rectifying their own mistakes. And the pharmacy kept a record of near misses. One of the dispensers said the near miss record was reviewed regularly for patterns, but the reviews were not documented. 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. A recent error had occurred where the wrong type of medicine had been supplied to a person. An incident report form had been completed and the correct medicine had been supplied.

There was an organised workflow in the dispensary which helped staff to prioritise tasks and manage the workload. And the workspaces were free from clutter. Team members used baskets were used to minimise the risk of medicines being transferred to a different prescription. And they initialled the dispensing label when they had dispensed or checked an item to show who had completed these tasks. One of the dispensers said that the accuracy checkers knew which prescriptions they could check as the pharmacist annotated these prescriptions. And she said that they would not check any if they had been involved with the dispensing process.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistants (MCAs) said that the pharmacy would open if the pharmacist had not turned up in the morning. They knew that they should not sell any medicines or hand out dispensed items before the pharmacist had signed in. And they were clear on which tasks they could carry out if the responsible pharmacist (RP) was absent from the premises.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the correct prescriber's details and the date on the prescription were not always recorded. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked around once a month. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. And any CD liquid overage was recorded in the register. There were signed in-date patient group directions available for the relevant services offered. 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 right responsible pharmacist (RP) notice was not on display at the start of the inspection, one was printed and displayed once pointed out. The RP record was largely completed correctly. But the pharmacist who had signed in before the pharmacy had opened had not signed out when he had left. And another pharmacist had taken over responsibility when the pharmacy had opened. The inspector spoke with the pharmacists and the record was updated to reflect the current RP.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Team members were using a person's smartcard who was not working on the day of the inspection. One of the dispensers swapped removed it from the docking station and replaced it with his smartcard. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out recently. The complaints procedure was available for team members to follow if needed. Team members were not aware of any recent complaints.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members were not aware of 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. And they are provided with some ongoing training to kelp keep their knowledge and skills up to date. They can raise any concerns or make suggestions about the pharmacy or its services. And team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one locum pharmacist, one pharmacy technician, three trained dispensers, one trainee dispenser and two trained MCAs working during the inspection. One of the dispensers was enrolled on the Overseas Pharmacists' Assessment Programme with a view to registering as a pharmacist in the UK. The trainee dispensers were enrolled on an accredited course for their role. Team members worked well together and they communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The MCAs appeared confident when speaking with people. They were aware of the restrictions on sales of medicines containing pseudoephedrine. They knew which medicines could potentially be abused or misused and said that they would refer to the pharmacist if a person regularly requested to purchase any of these medicines. They knew which questions to ask to establish whether a medicine was suitable for the person.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. Team members said that they were not provided with ongoing training on a regular basis, but they did receive some. Those enrolled on a pharmacy related course were allowed time during the working day to complete the modules. The pharmacist felt able to take professional decisions. And one of the pharmacists explained that she had carried out the necessary training for the Covid vaccination service. And she had the completed a declaration of competence and consultation skills training.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they said that they had ongoing informal performance reviews. 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 bright, clean, and tidy throughout which presented a professional image. It was secured from unauthorised access and 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 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 counter to help minimise the risk of conversations at the counter being heard.

The consultation room was accessible to wheelchair users. It could be accessed via a corridor to the left-hand side of the shop area. It was suitably equipped and well-screened. The room was not kept secured when not in use. This was discussed with the pharmacist and he explained that access to the corridor was needed by people accessing the foot clinic held in a room to the rear of the pharmacy. The pharmacist said that he would ensure that the door to the consultation room was closed in future. 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 provides its services safely and mostly manages them well. People with a range of needs can access the pharmacy's services. And the pharmacy responds appropriately to drug alerts and product recalls. It dispenses medicines into multi-compartment compliance packs safely. 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 with an automatically opening door. 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. A booking system for the Covid vaccination service was used to ensure that there was a qualified person available to administer the vaccines.

One of the dispensers said that people were not routinely asked for blood test results if they were taking higher-risk medicines such as methotrexate and warfarin. And 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. One of the dispensers said that they would ensure that prescriptions for higher-risk medicines were highlighted in future. Prescriptions for Schedule 3 CDs were highlighted, but prescriptions for Schedule 4 CDs were not. This could increase the chance of these medicines being supplied when the prescription is no longer valid. 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 additional warning cards or warning stickers available. One of the dispensers said that they would order some from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and the shelf edges were annotated with the date checked. Stock due to expire within the next three months was marked. And there were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. '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. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked every two months. Any uncollected items were returned to dispensing stock where possible after around two months. And the prescriptions were returned to the NHS electronic system or to the prescriber.

There were several team members involved with ordering prescriptions for the multi-compartment compliance packs and assembling the packs. This meant that cover could be provided if needed. The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in the packs. Prescriptions 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. Team members said that people usually requested these 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 but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. 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.

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. A team member said that the fridge temperatures were checked daily, but the temperature ranges were not reset after being checked. The maximum temperatures showing on the fridges were out of the appropriate range, but the current temperatures were within the range. The inspector discussed this with team members during the inspection. One of the dispensers said that they would ensure that the temperatures were checked and recorded properly in future.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But a record of any action taken was not kept, which could make it harder for the pharmacy to show what it had done in response. One of the dispensers said that he would ensure that an electronic audit trail was kept in future to show the action that had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment to help protect people's personal information.

Inspector's evidence

The phone in the dispensary was portable so it could be taken to a more private area where needed. And the pharmacy had access to up-to-date reference sources. And it had suitable equipment for measuring liquids, which was clean. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. There was a layer of medicine powder residue inside the electronic tablet counter, which may increase the chance of contamination. The counter was cleaned during the inspection and team members were reminded about the importance of ensuring that only certain medicines were counted this way. The fridges were suitable for storing medicines and were 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.