General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Osbon Pharmacy, 372 Rayleigh Road, LEIGH-ON-SEA, Essex, SS9 5PT

Pharmacy reference: 1031307

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

The pharmacy is located on a high street surrounded by residential premises. It is part of a small chain of pharmacies. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service. The pharmacy provides multi-compartment compliance aids to around 100 people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to around five people.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	Some members of the team are not undergoing training appropriate for their role. And this is not in accordance with GPhC minimum training requirements.
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 generally identifies and manages the risks associated with its services. It largely protects people's personal information. And seeks feedback from people who use the pharmacy. It mostly keeps its records up to date. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. Standard operating procedures (SOPs) were available. But there was no indication as to who had written them or when these had been produced. The pharmacist said that he would ensure that this was completed following a review of the SOPs. 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 not recorded. This could make it harder to spot patterns and minimise the risk of a similar mistake happening. A near miss log was printed during the inspection. The pharmacist said that he would ensure that the log was used and regularly reviewed for trends and patterns. This may help team members learn from any mistakes to help make the services safer. He said that he was not aware of any dispensing incidents since he started working at the pharmacy around nine months ago. And he would record any incidents on the designated form and carry out a root cause analysis.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped team members 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 trainee dispenser said that the pharmacy would open if the pharmacist had not arrived in the morning. He said that he would accept prescriptions and prepare them before the pharmacist arrived. He knew that he should not sell medicines or hand out dispensed items before the pharmacist had turned up. The inspector reminded team members what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance in place. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. The emergency supply record was completed correctly. But the prescriber details were not generally recorded on the private prescription record. The pharmacist said that he would remind team members to record this information.

Controlled drug (CD) running balances were checked around once a month. Liquid CD overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. Some headings were not completed in the CD registers. This could increase the chance of entries being made on the wrong page. There were alterations made to the register for one CD. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query. The responsible pharmacist (RP) log was completed correctly. And the correct RP notice was clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were sometimes shared. A Smartcard was in use which belonged to a member of the team who was not in the pharmacy during the inspection. Personal identification numbers (PIN) were on the Smartcards. This could make it easier for unauthorised people to gain access to people's personal information. The pharmacist said that he would ensure that team members used their own Smartcards and that these were kept securely when not in use without the PIN attached. Dispensed items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Over 99% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to refer to where needed. The pharmacist said that he was not aware of any complaints at the pharmacy since he started working there around nine months ago.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Team members said that they had not completed any safeguarding training. The trainee dispenser 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 trainee dispenser said that she was not aware of any safeguarding concerns at the pharmacy.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not ensure that all team members are enrolled on an accredited pharmacy course in a timely manner. This could mean that they do not have all the skills and knowledge they need to undertake their tasks safely. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The pharmacy has enough team members to provide its services safely.

Inspector's evidence

There was one pharmacist, one trainee dispenser (enrolled on an accredited dispenser's course) and three other members of the team working during the inspection. One member of the team said that he had worked at the pharmacy for around six years. He confirmed that he had completed the training for the medicine counter assistant (MCA) course. But he had not received a certificate to show that he had passed it. He said that he had worked in the dispensary since he started working at the pharmacy, but he had never been enrolled on an accredited dispenser's course. The second member of the team working in the dispensary said that she had worked at the pharmacy for around three to four years and had not been enrolled on an approved dispenser course. Another member of the team said that he had worked at the pharmacy for around one month (unpaid to gain experience). He was involved with restocking the medicines and other non-dispensing tasks.

The team worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The trainee dispenser appeared confident when speaking with people. He was aware of the restrictions on sales of pseudoephedrine containing products. The till would not allow more than one box to be sold in one transaction. He confirmed that he 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.

Team members confirmed that they did not take part in any regular ongoing training. But they said that they had recently completed some training about children's oral health. The pharmacist said that team members underwent an appraisal and performance review around one month ago. The trainee dispenser said that he had not received one with the previous owners. The pharmacist said that the team would undergo regular reviews of their performance. The trainee dispenser said that he felt confident to discuss any issues with the pharmacist. And that the pharmacist allowed changes to processes when needed. There were no formal pharmacy meetings. The pharmacist said that all information was passed on informally. A communication book was used for team members working on the counter to pass messages on. Targets were not set. The pharmacist said that he provided services for the benefit of people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. The pharmacist said that the pharmacy underwent a refit around eight months ago.

Pharmacy only medicines were kept behind the counter. Air-conditioning was available in the dispensary and shop area; the room temperature in these areas was suitable for storing medicines. The temperature in the store room upstairs felt warm. The pharmacist said that he would use a thermometer to monitor the temperature to ensure that medicines were being stored within the manufacturer’s recommendations.

There were six chairs in the shop area. Four of these were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. But two chairs were directly opposite the counter, outside the consultation room.

The consultation room was accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area. The windows in the doors were see-through. The pharmacist said that he would ensure that these were covered so that people’s dignity was protected. There were two chairs and a desk available. The room was accessible to wheelchair users. Access to the upstairs store room was via the consultation room. This could present an issue if the room was in use. The pharmacist said that he would display a notice on the back of the door to inform the team that the room was in use. This would minimise the chance of a team member walking into the room during a private consultation. 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. The pharmacy generally manages its services well. The pharmacy gets its medicines from reputable suppliers. But it does not always keep some of its medicines as securely as it should. This means that they may be less protected from unauthorised access. It responds to drug alerts and product recalls.

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. Services and opening times were clearly advertised. Team members said that they handled returned sharps containers without wearing gloves. This could potentially mean that they may be handling contaminated sharps containers. The trainee dispenser labelled a basket so that this could be used to transfer used sharps containers from the person returning it to the bin in the pharmacy.

The pharmacist said that he checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. A record of results was kept on the person's medication record. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for schedule 3 and 4 CDs were highlighted and included the date the prescription was due to expire. The pharmacist said that the pharmacy supplied valproate medicines to a few patients. But there were currently no people in the at-risk group using the pharmacy who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the patient information leaflets or warning cards available. The pharmacist said that he would order replacements from the manufacturer.

Fridge temperatures were checked infrequently; maximum and minimum temperatures were recorded for the first fridge. Records indicated that the temperatures were consistently within the recommended range for the first fridge. But no records were kept for the second fridge. The second fridge was of a type made for storing medicines at the right temperatures, and there were medicines kept inside it. The maximum temperature on the thermometer for this fridge was showing to be room temperature. But the temperature was monitored on the day of the inspection and was shown to be within the recommended range. The pharmacist said that the second fridge was new, and he would ensure that the temperatures of both fridges were checked and recorded daily.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next few months was clearly marked. Medicines were largely kept in appropriately labelled containers. But one box of tablets found with dispensing stock contained mixed batches and a dispensing bottle of medicines did not have the batch number recorded. This could make it harder for the pharmacy to respond to safety alerts or to date-check the medicines properly. The trainee dispenser said that she would ensure that all medicines were kept in appropriately labelled containers.

The trainee dispenser said that part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. And prescriptions for alternate medicines were requested from prescribers where

needed. Dispensed owed medicines did not have the prescription attached. There were several bagged 'owings' dispensed over six months ago waiting collection without prescriptions attached. The pharmacist said that the prescriptions had been sent to the NHS. This may increase the chance of the items being handed out when the prescription had expired. He said that he would keep a copy of the prescription with the dispensed items until collected so that this could be referred to if needed. Uncollected prescriptions were checked monthly. Items uncollected after around three months were returned to dispensing stock where possible. Uncollected prescriptions were returned to the prescriber or shredded in the pharmacy. Electronic prescriptions were returned to the NHS spine. And the patient's medication record was updated.

Prescriptions for people receiving their medicines in compliance aids were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people ordered these when they needed them. The pharmacy kept a record for each person which included any changes to their medication. They also kept hospital discharge letters for future reference. Compliance aids were suitably labelled and there was an audit trail kept on the persons record sheet to show who had dispensed and checked the compliance aids. Medication descriptions were put on the compliance aids. But patient information leaflets (PILs) were not routinely supplied. This could mean that some people do not get all the information they need to take these medicines safely. The trainee dispenser said that he would ensure that these were supplied in future.

CDs were generally stored in accordance with legal requirements and they were generally kept secure. A small number of medicines were not secured in accordance with the legislation. The pharmacist said that they would be stored properly in the future. 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 generally recorded in a register and destroyed with a witness; two signatures were recorded.

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. The driver had marked some as being posted through the letter box or left in the porch. The pharmacist said that he was not aware that this had been happening and he confirmed that he would speak with the driver to ensure that this did not happen in future.

Licensed wholesalers were used for the supply of medicines and medical devices. The pharmacist said that drug alerts and recalls were received from the suppliers. But he could not locate any recent ones during the inspection. The inspector showed the pharmacist how to sign the pharmacy up to drug alerts from the MHRA. The pharmacist said that he would keep a record of any action taken so that the pharmacy could show what had been done in response.

The pharmacy has the equipment installed ready for the implementation of the EU Falsified Medicines Directive. The pharmacist said that the equipment was not currently in use and team members had not received training on how to use the equipment. He said that the superintendent pharmacist was in the process of writing an SOP for the process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

Inspector's evidence

Suitable equipment for measuring medicines was available. A separate measure was marked for CD use only. But the pharmacist said that he used an oral syringe to measure quantities of CDs less than 5ml. He confirmed that he would use a suitable measure in future. Triangle 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 was not sure how long the blood pressure monitor had been in use for. He said that he would check and replace it if needed. The phone in the dispensary was portable so could be taken to a more private area where needed. The shredder was in good working order.

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.