General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Golden Cross Pharmacy, 10 Goldon Cross Parade, Ashingdon Road, ROCHFORD, Essex, SS4 1UB

Pharmacy reference: 1031340

Type of pharmacy: Community

Date of inspection: 06/01/2020

Pharmacy context

The pharmacy is an independent pharmacy located on a parade of shops near to a village centre in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and the NHS Health Checks. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to a large number of 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: 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 met	2.4	Good practice	The pharmacy has a good culture of learning. They learn from any mistakes and are supported with keeping their knowledge up to date. And they receive regular feedback and this is documented.
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 and operates in a safe and effective manner. 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. And team members understand their role in protecting vulnerable people. The pharmacy regularly seeks feedback from people who use the pharmacy and it generally protects people's personal information. And it generally maintains the records it needs to keep by law.

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. 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 by the dispenser. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser explained that team members had rearranged the stock so that it was stored in alphabetical order by generic name and this had reduced the number of errors made. Dispensing incidents where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. The superintendent (SI) pharmacist said that there had not been any recent dispensing incidents. He said that the dispensing process had changed due to a dispensing incident some time ago, and team members now selected the item before producing the labels. He said that this had helped to minimise the chance of the wrong medicine being selected.

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 dispenser said that the pharmacy would open if the pharmacist had not turned up in the morning. She knew that she should not carry out any dispensing tasks or sell any medicines before the pharmacist had arrived. The trainee medicines counter assistant (MCA) knew that she should not sell pharmacy-only medicines or hand out bagged items if the pharmacist was not 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. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals and liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. There were several occasions when the pharmacist had not completed the log at the end of their shift. The SI said that he would ensure that the log was completed correctly in the future. The

private prescription records were completed correctly, but there were several prescriptions which had not been entered within the required timeframe. The dispenser said that she would ensure that these were entered promptly in the future. There were several private prescriptions that did not have the required information on them when the supply was made. And one prescription was not written on the correct form. The SI said that he would ensure that all prescriptions were written on the correct form and had all the required information on them. 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 SI said that he would ensure that the nature of emergency was recorded in the future.

Confidential waste was shredded, but the shredder was not a 'cross-cut' type and some information could be read after it had been shredded. The SI said that he would request that all team members place paper in the shredder in such a way that the information was shredded properly. He said that he would order a more suitable shredder. 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. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser explained about an occasion recently when there had been a complaint received. She said that she was not working at the pharmacy when the complaint was made, but she had been a made aware and a report had been completed and sent to NHS England. The pharmacy underwent 'mystery shopper' visits every few months. Recent results were positive and the pharmacy had received an average of around 97% for all the previous visits. This was considerably higher than the average for other competitors which was around 64%.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed some safeguarding training provided by the pharmacy and the dispenser was in the process of completing the CPPE training. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI said that there had not been any safeguarding concerns at the pharmacy. 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 manage its workload. It provides team members with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. 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.

Inspector's evidence

There was one regular pharmacist, one trained dispenser and one trainee dispenser working during the inspection. The SI was at the pharmacy on the day of the inspection to carry out the 'end of month' processes. He explained that he also worked in the pharmacy when additional cover was needed. Most team members had completed an accredited course for their role and the rest were undertaking training. They 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. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The dispenser completed regular training modules provided by the CPPE, including sepsis, safeguarding and she was due to undertake risk management training and training about 'look alike and sound alike' medicines. She said that she was allowed time each week to complete the training in work. Team members also had regular reviews of any dispensing mistakes and discussed these openly in the team. The trainee dispenser was in the process of completing modules for the dispenser course.

The pharmacist said that she felt able to take professional decisions. She said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. She explained that she had been providing the influenza vaccinations in her previous employment, but she had not done any at this pharmacy yet.

The dispenser explained that monthly meetings were held to discuss any issues, near misses and dispensing incidents. She said that a meeting was due to be held in the near future as the regular pharmacist had only worked at the pharmacy for around one week. The SI explained that a business mentor from Alphega visited the pharmacy every few months to have '1-2-1' meetings with all team members which included an appraisal and performance review. The SI was provided with a 'contact report' for each meeting. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The pharmacist said that she carried the services for the benefit of the people who used 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 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 was one chair in the shop area. This was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The room could be accessed from the shop area and the dispensary. A small table restricted access to the dispensary and the sharps bin could not be accessed by people using the room.

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. People with a range of needs can access the pharmacy's services. And the pharmacy takes extra care with prescriptions for higher-risk medicines and these are highlighted. So, that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and generally 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.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power assisted 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.

The pharmacy was in the process of carrying out audits for people taking some higher-risk medicines, including methotrexate, lithium, non-steroidal anti-inflammatories. And one for people with diabetes. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to reduce the chance of these medicines being supplied when the prescription was no longer valid. The trainee dispenser knew that these prescriptions were only valid for 28 days. 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. The pharmacist said that she would order replacements from the manufacturer. The dispenser knew that the warning cards should be given each time the medicine was dispensed, and these cards were already attached to the packaging for most of these medicines.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked frequently and this activity was recorded. Stock due to expire within the next months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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. 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 weekly and bagged items for the same person were banded together. The dispenser said that items uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. She explained that she attempted to contact the person or the surgery to let them know before their items were returned to dispensing stock.

The pharmacist said that assessments for the people who had their medicines in multi-compartment compliance packs were carried out by people's GPs. 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; the dispenser said that the pharmacy contacted people to see 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, but the backing sheets were not always attached to the packs. This could increase the chance of them being misplaced. The dispenser said that she would ensure that they were attached in the future. Medication descriptions were generally put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The dispenser explained that the pharmacy was in the process of adding the descriptions to the dispensing labels. The dispenser said that team members used alcohol gel on their hands before assembling the packs and tweezers were also available.

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; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not routinely record people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The delivery driver said that she would obtain signatures in the future and she would ensure that other people's personal information was protected when doing this. 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 dispenser explained that prior consent was obtained from people before items were posted through letter boxes and this was recorded on the person's medication record.

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. There was an open delivery box at the medicines counter with some prescription-only medicines inside. The inspector pointed it out to the trainee dispenser and she closed the box. But there were several other boxes in the shop area containing prescription-only medicines. These were moved into the dispensary during the inspection. The dispenser said that the boxes were not usually left in the shop area, but there was a dispenser on unplanned leave on the day of the inspection.

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 dispenser said that she had undertaken some training on how the system worked. She said that not all of the medicines could be scanned, but those with a 2D barcode were being scanned.

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 and separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Methotrexate came in foil packs and there was little need for the loose tablets to be counted out in a triangle. 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 SI said that he was not sure how long the blood pressure monitor had been in use for, but he explained that blood pressure checks were not usually offered at the pharmacy. The weighing scales and the shredder 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.