General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 42 West Street, ROCHFORD, Essex, SS4 1AJ

Pharmacy reference: 1031342

Type of pharmacy: Community

Date of inspection: 07/11/2019

Pharmacy context

The pharmacy is located in a small town centre in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, a stop smoking service, and a weight management service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. It supplies medicines to four nursing homes. 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	Good practice	2.2	Good practice	The pharmacy encourages its team members to undertake ongoing training. And it gives them time set aside to do it. This helps them keep their knowledge and skills up to date.
		2.5	Good practice	Team members are comfortable about raising concerns about the pharmacy or other issues affecting people's safety. And they can make suggestions about how to improve their procedures.
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. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people’s personal information well and it regularly seeks feedback from people who use the pharmacy. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. 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. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood. 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. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The person had not taken any of the medicine and it was replaced with the right medicine. The incident had been reported to the pharmacy’s head office and the different strengths were now kept separated. The pharmacy received a monthly patient safety incident report from the pharmacy’s head office. This was reviewed by the pharmacy team and any changes were implemented where needed.

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 medicines counter assistant (MCA) said that the pharmacy’s head office would be informed if the pharmacist had not turned up. She explained that the pharmacy would open and she knew that she should not sell any medicines or hand out dispensed items until the pharmacist had arrived. One of the pharmacy technicians explained that she would not carry out any dispensing tasks if there was no responsible pharmacist signed in.

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. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. The emergency supply record was completed and all necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date Patient Group Directions available for the relevant services offered. The private prescription records were mostly completed correctly, but the prescriber’s address was not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the suppliers were not usually recorded.

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.

Confidential waste was 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. 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 2018 to 2019 survey were available on the NHS website. Results showed that over 90% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed. Team members were not aware of any recent complaints.

The pharmacist and pharmacy technicians had completed the Centre for Pharmacy Postgraduate Education training (CPPE) about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy's head office. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And she gave an example of action the pharmacy had taken in response to a safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided 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. The team discusses adverse incidents and uses these to learn and improve. 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. These are not affected by the pharmacy's targets.

Inspector's evidence

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

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Warnings appeared on the screen on the tills for some pharmacy-only medicines and this prompted team members to ask for assistance from the pharmacist. Effective questioning techniques were used to establish whether the medicines were suitable for the person. The dispenser was observed referring a person to the pharmacist for advice about medicine for their child. She explained the concern well to him and then he spoke with the person.

Team members were provided with regular ongoing training by the pharmacy's head office. They were allowed time during the working day to complete the modules, and they could also access the training at home. They had recently completed some training about how to reduce errors involving medicines which looked alike or sounded alike. The pharmacist regularly checked the online training to ensure that team members completed it within the required timeframe. The pharmacy also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist and pharmacy technicians were aware of the continuing professional development requirement for the professional revalidation process. They had recently completed training provided by the CPPE about sepsis, and they were in the process of completing risk management training.

The pharmacist said that he felt able to make professional decisions. And he explained that he had a good working relationship with the local surgeries. He had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They had yearly appraisals and performance reviews, as well as regular meetings. The pharmacy technician said that the pharmacist had allowed team members to make suggestions and changes to how the multi-compartment compliance packs were managed. She explained that the new system made it more manageable and that several team members could now manage it when people were on leave.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that the pharmacy usually reached the targets. He explained that there was a certain amount of pressure for the pharmacy to meet the targets but he would not let this affect his professional judgement. And he provided 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 were four wipe-clean chairs in the shop area. These were 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.

Toilet facilities were clean and there were separate hand washing facilities available. The toilet area was large and it was being used to store excess stock on the day of the inspection. The pharmacist explained that this was not usually stored in there but the new computer system had been overordering some items. The pharmacy technician said that she would clear some space in the kitchen area for these and she would ensure that medicines were not stored in there in the future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and 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. 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. Team members had a clear view of the main entrance from the medicines counter and dispensary, and they 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 induction hearing loop appeared to be in good working order.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that he would keep a record of these in the future. 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 minimise the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacy technician said they 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 was currently only one person in the at-risk group who needed to be on a Pregnancy Prevention Programme. Their medication record was annotated with this and the pharmacist said that he had discussed it with them. The pharmacy had the relevant patient information leaflets and warning cards available.

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 six months was marked. There were several 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 pharmacist said that he would ensure that medicines were kept in their original packaging in the future.

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. The pharmacist said that uncollected prescriptions were checked around once a week. He explained that people were usually contacted if their medicines remained uncollected after around six weeks. Uncollected prescriptions were returned to the NHS electronic system or kept at the pharmacy so that they could be re-dispensed if needed. Uncollected items were returned to dispensing stock where possible.

The pharmacist said that the pharmacy and surgeries ensured that people who had assessments carried out 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. Prescriptions for 'when required' medicines were not routinely requested; the pharmacy technician said that people contacted the pharmacy when 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 attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were not put on the packs to help people and their carers identify the medicines and patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacy technician said that she would ensure that the backing sheets were attached, medications descriptions added and the patient information leaflets supplied in the future. The nursing homes were responsible for ordering prescriptions for their residents. The pharmacy prompted them when to order the prescriptions. A chart was used to record when the prescriptions were ordered, chased, labelled, dispensed, checked and delivered. Communication folders and a diary were used to ensure important information was passed on to the relevant people. The pharmacist said that someone from the pharmacy's head office care management team visited the nursing homes at regular intervals to carry out medicines audits. 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; 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. 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 pharmacy's head office. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive and it was being used fully. Team members had undertaken training on how the system worked. And there were written procedures available.

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. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was calibrated yearly and the shredder was in good working order. The carbon monoxide testing machine was calibrated by an outside agency. 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 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.