

Registered pharmacy inspection report

Pharmacy Name: Well, 7 Station Road, Harold Wood, ROMFORD,
Essex, RM3 0BP

Pharmacy reference: 1031374

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

This pharmacy is located in a residential area opposite a train station and mainly serves the local population which are mostly older people. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It provides Medicines Use Reviews, the New Medicine Service and provides flu vaccinations.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
2. Staff	Good practice	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors it. This helps team members keep their knowledge and skills up to date.
		2.4	Good practice	Team members are regularly provided with feedback There is a culture of learning, continuous improvement and personal development.
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 identifies and manages the risks associated with its services to help provide them safely. Team members are good at recording and regularly reviewing any mistakes that happen during the dispensing process. This helps them make the pharmacy's services safer. The pharmacy protects people's personal information well and it regularly 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

Standard Operating Procedures (SOPs) were up to date and were reviewed by head office. Team members were required to read SOPs on the e-learning tool 'E-Expert'. Team members were assigned SOPs depending on their roles and had to complete an assessment and declaration at the end of reading each SOP. Compliance was checked by the regional audit manager. Locum pharmacists had to read certain SOPs before working for the company and were sent SOPs electronically before starting work.

Near misses were discussed with the team and recorded on a paper form as they were identified and these were then transferred to an electronic recording system called 'Datix'. Depending on the type of near miss a record code was generated by Datix, near misses which were a result of look-alike sound-alike (LASA) medicines were also highlighted. At the end of each month the team completed a patient safety review using data generated by Datix. If a certain trend was picked up, the responsible pharmacist (RP) discussed this with team members at the weekly huddle or at the monthly patient safety review. Near misses were observed to be recorded. At the last review which had looked at near misses from November 2019, the team had discussed setting up a 'model working day' as part of which they would set times for completing processes. The team had also discussed being more organised as they were due to approach the busier Christmas period. The RP had completed a training module on LASA medicines and also briefed the team. Team members were encouraged to be open and honest. The company issued monthly Share and Learn bulletins which team members read and discussed at the monthly meeting; the latest bulletin had advised team members to read things properly and carefully. Team members were also encouraged to: report, learn, share, act and review when an incident occurred.

Dispensing incidents were also reported on Datix. The RP described the steps he would take when an incident was reported which included: finding out what had happened, having a discussion with the person, finding out if they had taken the incorrect medication, contact the GP and referring the person to their GP or hospital if they had administered the incorrect medication. Incidents were discussed on the day with the team and also at the weekly huddle. The RP said that there were no reported incidents since he had started working at the branch, but the team members had been asked to relook at guidance for handing out controlled drugs (CDs) after a CD had been handed out without showing the RP.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and a displayed notice explained to people how they could make a complaint. Annual patient satisfaction surveys were also carried out. Most feedback received was usually positive, there had been some feedback around the waiting times; as a result of this team members were advised to talk to

people about the process and a leaflet had been displayed also explaining how the process worked. Following a change in the dispensing service the team had displayed a poster asking people to order their prescriptions a week in advance.

The correct RP notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Records for private prescription, emergency supplies, RP and CD registers were well maintained. CD balances were checked regularly. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register as they were received. Records for unlicensed medicines supplied were not kept; the RP gave an assurance that he would brief the team and ensure these were done in future.

Assembled prescriptions were stored securely and were not visible to people using the pharmacy. The pharmacy had an information governance policy in place, this was also available on the intranet and all team members had looked through these. Relevant team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR); consent to access these was gained verbally. All team members had also completed training on confidentiality on the E-Expert, the company's online training system and signed a confidentiality agreement. An audit had also been completed to see how confidentiality was being managed. Computers were password protected.

Safeguarding resources were available on the intranet. Team members had completed safeguarding training on E-Expert. The RP had also completed level 2 safeguarding training. Details were available for the local safeguarding boards and the company had a safeguarding policy in place. Safeguarding was also discussed as part of the patient safety review.

Principle 2 - Staffing ✓ Good practice

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. And there is a good culture of learning and personal development in the pharmacy. Team members get time set aside for ongoing structured training. This helps them keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the pharmacy manager (RP), and three trained dispensers who also covered the medicines counter.

The RP felt that at the time of the inspection there was a sufficient number of staff. However, the pharmacy was moving to having prescriptions dispensed at the hub. As a result of this, a team member was due to leave within the near future.

Staff performance was managed by the RP with two reviews held each year. During the review the RP and team member discussed positives and negatives and what could be done to improve. Team members were then given a score using a scoring system. The RP liked to get team members trained on different areas and this was looked at as part of the review. The RP had trained all team members to dispenser level so that everyone was aware of how to do everything. All team members were also trained to be healthy living champions. One of the dispensers was due to be enrolled onto the technician training programme.

Each week the intranet gave an indication of any training modules that needed to be completed. The E-Expert system also identified this. Team members were given time in store to complete their training modules. Once everyone had completed the training module, the team held a huddle to discuss what they had learnt. The RP had completed a module on sepsis recently and had a discussion with the team on what he had learnt, including signs and symptoms. Pharmacy magazines also had training modules which team members completed. E-Expert had mandatory and optional modules. Where time was available the RP would ask team members to pick optional modules to complete, make some notes and then brief their colleagues. The team had not been able to do this recently with the new changes that had been implemented.

The team held weekly huddles and a monthly patient safety review and also discussed things as they came up. The RP also had a one-to-one each week with a different team member to discuss things that they had done and an area where they needed to improve. The company had a bronze, silver and gold stars recognition scheme to reward and recognise colleagues for their work. Colleagues were presented with badges and vouchers as part of the recognition scheme.

The team received 'Share and Learn' bulletins from head office and were also sent weekly reports by the regional divisional manager. These reports discussed budgets etc. The company's intranet also had information and alerts. The RP was the regional professional lead and shared information with other branches.

Targets were in place for services provided. Team members said that there was an element of pressure to meet these targets. However, the targets did not affect the RP's professional judgement.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are clean and tidy. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean, tidy and bright. The dispensary was spacious with ample workbenches allocated for certain tasks. Workbench space was clear and organised. An area at the back of the dispensary was used to prepare and manage the multi-compartment compliance pack service. Cleaning was carried out by team members. A sink was available for the preparation of medicines. Medicines were stored on shelves in an organised and tidy manner. Assembled prescriptions awaiting collection were stored in cupboards with frosted doors. The pharmacy had a flat roof which was leaking in the area on top of the checking bench.

A diverter had been attached to divert any water away from medicines. The company was in the process of arranging for the leak to be repaired.

The consultation room was spacious, clean and tidy. There were a number of leaflets displayed within the room. The room was usually kept locked when not in use but had been unlocked at the time of the inspection. Conversations held within the room could not be overheard. Some prescription-only medicines had been stored in the room. These were removed during the course of the visit..

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. Air conditioning was available to help regulate the temperature in the dispensary.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy largely delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

Access into the pharmacy was step free with an automatic door. There was space for the movement of a wheelchair or pushchair and chairs were available in the waiting area for customers. Team members were multilingual; people in the local area predominantly spoke English. A hearing loop was available. Team members aimed to make people feel as comfortable as possible and had previously had a person who team members would go out and serve. The pharmacy also offered a delivery service and altered delivery regimens for some people so that the driver could check on them weekly. The pharmacy had the ability to produce large print labels, and many original medicine packs had braille on boxes. The team also printed out information from other sources such as the NHS websites to reinforce and counsel people.

The pharmacy had details available for other local services as part of being a Healthy Living Pharmacy. Leaflets were also available in the consultation room which were handed out to people. Team members referred people to other local services such as Zumba sessions and to local smoking cessation clinics. A list of services provided locally was kept in a folder. The pharmacy also had a good relationship with the Rainbow Trust and helped to fundraise for them and for the Stroke Association.

As part of the Healthy Living Service the pharmacy ran campaigns in line with NHS and national promotions. At the time of the inspection, the team were running a campaign on dry January and had leaflets displayed at the counter. A number of services previously offered by the pharmacy had been decommissioned. The pharmacy no longer provided a smoking cessation service but trained team members were able to counsel people and support them.

The RP felt that the New Medicine Service helped to pick up problems at the early stages and also people felt supported at the start of their treatments or if they had been newly diagnosed. Team members were briefed to be empathetic. The pharmacy also provided the NHS Community Pharmacist Consultation Service (CPCS) and had six referrals since the service had started.

The pharmacy had an established workflow in place. Repeat prescriptions were entered onto the system and sent to the hub. To submit a prescription to the hub more than 50% of the items needed to be able to be dispensed at the hub. Clinical checks on the prescriptions were done in the store. The prescriptions were entered onto the system and placed in a yellow basket, items were annotated with a 'H' or 'L' depending on where they were due to be dispensed. The RP went onto the computer at various times of the day and carried out a clinical and accuracy check and then submitted the prescriptions to be dispensed. Dispensed items were sent back from the hub in a separate coloured tote with a barcode which needed to be scanned. When prescriptions were scanned onto the shelves people were automatically sent a message to notify them that their prescription was ready. When the service had initially launched the team had to check the first 300 items to identify if there were any problems. As part of the quality assurance process each day when the delivery was received, the RP

needed to check three packs (one with medicines dispensed in store, one fully dispensed at the hub and one part dispensed at the hub). If there were any issues found these were reported on Datix. The pharmacy had not identified any issues in the last three months since they had gone live on the system. Items which were not dispensed at the hub included: CDs, fridge lines and liquids.

Prescriptions dispensed in store were usually dispensed by one of the dispensers and then checked by the RP. The RP very rarely had to self-check and if needed would take a mental break between dispensing and checking. The computer system had an electronic code which recorded who had labelled the prescriptions. Dispensed and checked-by boxes were also available on labels, and RP records had the pharmacists checking initials recorded. Before submitting prescriptions to the hub, team members needed to log in with individual passwords. Locums were set up on the system using their smartcard before the started work or a team member could do it on the day. Colour-coded baskets were used as part of the dispensing process to separate prescriptions and to help manage the workflow.

All team members had been trained on the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Team members checked with people who fell in the at-risk group if they had spoken to their GP and signed an agreement. If not, the person was advised to speak to their GP. The initial consultation was held in the consultation room and a note was made on the person's electronic record. The pharmacy had also completed an audit as part of which four people had been identified who fell in the at-risk group. The RP said that as local surgeries issued three monthly prescriptions he had called the people in and spoken to them. The team were aware of the need to use the warning labels and stuck the 'pharmacist advise' sticker on the prescription so that the RP could chat to the person. There had been two phases to the audit which had been discussed at the huddle. Sodium valproate was stored in a segregated drawer with warning stickers to prompt the team.

For other high-risk medicines, stickers were stuck onto the prescription form and team members asked people who were collecting warfarin for their yellow book. The pharmacy was in the process of running an audit on five different medicines including lithium. Reminders were attached to the prescriptions and for some of the categories the questions could be asked by the team member. An example given included the diabetes audit as part of which people were asked if they were having their feet and eyes checked regularly. For the other medical conditions, a 'pharmacist' sticker was attached to the prescription and the person was asked into the consultation room. INRs were recorded on the electronic patient record. The new system had a separate section to record INR.

The pharmacy had a list of people whose multi-compartment compliance packs were due each week. Prescriptions were ordered by the team and on arrival were labelled with a check completed for any missing items or changes. These were then queried with the GP and a record of the change was requested in writing. A note of this was made on the person's individual record. Packs were prepared by dispensers once all the items were available. People had annual reviews with their GPs; the pharmacy did not carry out any reviews on an ongoing basis to assess people's suitability for the service.

Assembled multi-compartment compliance packs observed were labelled with mandatory warnings and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were not seen in one of the bags checked which was awaiting collection. Other bags were seen to include leaflets. Product descriptions were missing from the assembled packs seen, team members said that this had happened since the new system had been installed. This could result in patients and carers not always be able to identify which medicines are which. The team gave assurances that they would start recording descriptions.

CD stickers were attached to prescriptions for CDs, the expiry date was also recorded on these to ensure they were not handed out after the prescription had expired.

Signatures were obtained for all medicines delivered to people. The pharmacy was due to move to an electronic system to obtain signatures. In the event that someone was not available, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely. There were two loose flu vaccinations found stored in the fridge. These were not stored in line with the manufacturer's guidance and the RP gave assurances that he would discard them.

Expiry date checks were carried out in accordance to a matrix available on the intranet which allocated sections to be checked monthly. Short-dated stock was marked and documented on the system. The system highlighted what had expired each month. There were no date-expired medicines found on the shelves checked. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

The RP was unsure if the pharmacy was compliant with the Falsified Medicines Directive (FMD). He said that medicines were decommissioned at head office. Team members had completed an E-Expert module.

Drug recalls were received on the intranet. These could be accessed by all team members. They were actioned and filed in the dispensary and the team member who had actioned the recall signed when they had completed. The pharmacy had to complete daily health and safety checks and conform when this was done. The last actioned alert had been for paracetamol tablets.

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 calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. A separate tablet counting triangle was used for cytotoxic medicines to avoid contamination. A fridge of adequate size was available. A blood pressure monitor was available which was calibrated by an external company.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was segregated and collected by a contractor for destruction.

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.