General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Audley Mills Pharmacy, 39 Eastwood Road, RAYLEIGH, Essex, SS6 7JE

Pharmacy reference: 1031378

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre and it is surrounded by residential premises. 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, the New Medicine Service, healthcare checks and a stop smoking service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a large 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people and take appropriate action when needed. The pharmacy mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

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). The dispenser said that 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 being recorded and there were no review processes carried out to check 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. The dispenser said that any dispensing incidents would be reported to the pharmacy's head office by the pharmacist. She confirmed that she was not aware of any recent dispensing incidents.

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 not open if the pharmacist had not turned up. She confirmed that she would contact the pharmacy's head office to inform them. And explained that she would not carry out any dispensing tasks until the pharmacist had arrived. She was confident about which tasks should not be carried out 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. The emergency supply record and the private prescription record were completed correctly. But, the pharmacy had not kept the private prescription record up to date for around one month. The dispenser said that she would ensure that entries were made in a timely manner in future. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running balances were checked frequently. Liquid 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. The responsible pharmacist (RP) log was largely completed correctly and the correct RP notice was clearly displayed.

Confidential waste was shredded, 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 survey were available on the NHS website. Results were positive and 100% of respondents were satisfied with the service received from the pharmacist and other staff. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The medicines counter assistant (MCA) said that she was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy's head office. The dispenser 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 ✔ Standards met

Summary findings

The pharmacy has an adequate number of team members for its services. However, some team members have left and have not been replaced and this has sometimes created staff shortages on occasions. And being without a manager increases the workload on other team members. But overall, the team is managing the workload appropriately and prioritising tasks when needed. The team members can take professional decisions to ensure people taking medicines are safe. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. But they are not always able to complete available training. This could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one locum pharmacist, two trained dispensers and one trained MCA working at the pharmacy during the inspection. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised. Team members explained that they worked additional hours to cover people's leave and any unplanned sickness. The pharmacy was currently without a permanent pharmacy manager. And the dispenser said that in their absence she completed managerial tasks.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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.

All team members had completed accredited training courses for their role, and certificates were displayed in the dispensary. The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. The dispenser said that team members did not undertake any ongoing training due to not having time to complete it during the working day. The pharmacist felt able to take professional decisions.

The dispenser said that appraisals and performance reviews had not been carried out. But she felt comfortable about raising concerns and making suggestions. Team members said that they had raised the issue about not having a manager with the cluster manager on several occasions. But they were not sure if there were any plans to replace the manager who had left around four months ago. They explained that this was the second prolonged period that the pharmacy had been without a manager within the last eight months. And they talked about the impact this had on the pharmacy team. The pharmacy did not have regular meetings. But the team had arranged for an informal meeting to be held to discuss staffing levels over the Christmas period. Team members used a group text messaging system so that they could communicate any issues and organise 'last-minute' cover when needed.

Following the inspection, the inspector contacted the pharmacy's superintendent office and was provided with assurances that the pharmacy staffing levels would be reviewed and assistance provided if needed.

Targets used to be set for Medicines Use Reviews and New Medicine Service. The dispenser said that the pharmacy used to meet the targets, but team members had been told that the targets did not apply while the pharmacy was without a manager.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area. The premises are suitable for the pharmacy's services. But the pharmacy could do more to ensure that routine maintenance issues are addressed promptly. And to make sure that the room temperature in the summer months remains at a suitable level.

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.

Some of the drawers in the dispensary were broken or did not close properly. These potentially posed a tripping hazard to team members. The dispenser said that this had been reported to the area manager, but the issue had not been resolved. The maintenance was discussed with the pharmacy's superintendent office following the inspection and they provided assurances that these issues would be addressed.

Air conditioning was not available; however, the room temperature was suitable for storing medicines on the day of the inspection. But the dispenser said that team members were allowed to wear their own clothing during the summer months as the room temperature in the pharmacy had at times become very warm. This was discussed with the pharmacy's superintendent office following the inspection. They provided assurances that the room temperature would be monitored and any necessary action taken if needed.

There were two chairs with arms to aid standing in the shop area. These were positioned near to the medicines counter which meant that conversations at the counter could easily be heard. The dispenser said that team members would offer the use of the consultation room if someone wished to discuss something in a more private setting.

The consultation room was accessible to wheelchair users and was located next to the medicines counter. 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 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. 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. 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. 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 induction hearing loop appeared to be in good working order. The dispenser said that the usual enhanced pharmacy services had been put on hold due to the pharmacy not having a manager for around six months. The pharmacy team were having issues with the NHS electronic prescription service during the inspection. One computer would not allow access to the system and the other computer would not allow a refresh.

A dispensing bottle was found next to the sink in the dispensary. It had several dispensing labels on and appeared to have been used multiple times to dispense methadone for supervised consumption. The dispenser said that she would remind the pharmacist who had done this, to use a new bottle each time. There was water residue in the bottle which may dilute the strength of the medicine.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she would checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But she was not sure if a record of blood test results was kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. So, there may be chance that these could be handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispenser said they checked CDs and fridge items with people when handing them out. The dispenser 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 dispenser said that she would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. The expiry date checks had not been carried out properly for a long time. Some short-dated items were marked but most weren't. There were several date-expired items found in with dispensing stock and some had expired over a year ago. The dispenser said that team members had been prioritising other tasks over this.

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. The dispenser said that uncollected prescriptions were checked regularly and people used to be sent a letter if they had not collected their items after around six weeks. But team members had not been doing this recently due to time constraints. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that assessments were carried out for people who had their medications dispensed into multi-compartment compliance packs. Prescriptions for people receiving their medicines in the 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. 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. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

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. The dispenser said that drug alerts and recalls were received from the pharmacy's head office and some recent ones had been actioned. But, the record which showed what action had been taken, had not been kept up to date since June 2019. This could make it harder for the pharmacy to show what it had done in response.

The dispenser said that some equipment had been recently installed in the pharmacy, and she thought that this was to comply with the EU Falsified Medicines Directive. It was not yet being used and the dispenser had not received any training. She was not sure when team members were due to start using the equipment.

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 liquid controlled drug use only. 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 weighing scales 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.