General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Deejay Pharmacy, Campfield Road, Shoeburyness, SOUTHEND-ON-SEA, Essex, SS3 9BX

Pharmacy reference: 1031408

Type of pharmacy: Community

Date of inspection: 28/03/2023

Pharmacy context

The pharmacy is in a largely residential area near a parade of shops and a medical centre. It provides a range of services, including the New Medicine Service and a flu vaccination service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy receives most of its prescriptions electronically. And 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. These are dispensed at another pharmacy within the company.

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 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. The pharmacy protects people's personal information. And team members know what to do to ensure that vulnerable people are protected. The pharmacy mostly keeps its records up to date and they are largely accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood and agreed to follow them. The pharmacy recorded near misses, where a dispensing mistake was identified before the medicine had reached a person. The pharmacist informed team members about their mistakes and they were responsible for identifying and rectifying them. The near miss record was 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. The pharmacist explained that most of the errors were where the wrong quantity of a medicine had been dispensed. Team members were reminded to check their counting before passing to the pharmacy to be checked. The results of the reviews were discussed openly during the team meetings. Dispensing errors, where a dispensing mistake had reached a person, were recorded on the pharmacy's computer system and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The pharmacy had followed its procedures and informed the person's GP. The pharmacist showed how the pharmacy kept a record on people's medication record of any allergies so that the pharmacy could intervene at the earliest opportunity to ensure there was minimal delay if a prescription for an alternate medicine was needed.

There was an organised workflow in the dispensary which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was free from clutter and 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. The accuracy checking technician (ACT) said that she would only carry out an accuracy check on a medicine if the prescription had already been clinically checked by the pharmacist. And she knew that she should not check items that she had dispensed.

The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. But she would not sell any medicines or hand our dispensed items. And she knew that she should not sell any pharmacy-only medicines if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. The pharmacist said that he would ensure that these details were recorded in future. Controlled drug (CD) registers examined were filled in correctly.

The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacy did not carry out balance checks in accordance with its SOPs. The pharmacist said that he would review the frequency and ensure that what was being done matched the SOPs. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there were several missed entries where the pharmacist had not completed the log when they had finished their shift and a different pharmacist was working the following day. This was discussed with the pharmacist during the inspection.

Team members had completed training about how to protect people's personal information. The pharmacy shredded its confidential waste. 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 complaints procedure was available for team members to follow if needed and the pharmacist said that he would deal with any complaints. He said that there had not been any recent complaints, only positive feedback from a person who had felt that the pharmacy had gone above and beyond for them recently.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. They could describe people who might be classed as vulnerable and would refer any concerns to the pharmacist. There had not been any safeguarding concerns at the pharmacy. One of the pharmacy technicians said that the pharmacy's consultation room had recently been approved for use as a 'safe space'.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and they get regular feedback about their performance. And they can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular full-time pharmacist (who was also the superintendent pharmacist), two pharmacy technicians, two trained dispensers and one trained MCA working during the inspection. The workload was well managed and team members communicated effectively with each other thought the inspection.

The MCA appeared confident when speaking with people. She would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she was aware of the restrictions on sales of pseudoephedrine-containing products. She asked questions to establish whether an over-the-counter medicine was suitable for a person. And the questions were displayed behind the counter for team members to refer to if needed.

The pharmacist and pharmacy technicians were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist felt able to take professional decisions. And he said that targets were not set for team members. One of the dispensers explained that the pharmacist provided team members with a list of training requirements but in addition to this she did some other training modules online. She explained that team members could use the pharmacy’s computers during their breaks, or the training could be done at home.

Team members said that there were informal huddles to discuss any issues and allocate tasks. One of the team said that if someone was not at work then other team members could cover their work. The team used a messaging service to ensure that important information was passed to all team members. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had yearly appraisals and performance reviews.

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 which 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, and the room temperature was suitable for storing medicines.

There was one chair in the shop area for people to use while waiting. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There were some storage boxes containing excess stock in the consultation room. The room could still be used for people to have a conversation in a more private area. And people were not left unattended in the room. The room was well screened and accessible to wheelchair users. 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

The pharmacy provides its services safely and manages them well. The pharmacy manages prescriptions for controlled drugs and other higher-risk medicines to ensure that these are supplied safely and before the prescription has expired. The pharmacy uses reputable medicine suppliers, and it generally stores its medicines 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

Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And access to the pharmacy was step-free with a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy provided large print labels for people who needed them.

One of the pharmacy technicians explained that the pharmacy routinely 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 patient's medication record. 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 clearly highlighted to indicate that they were only valid for 28 day and that the ones for Schedule 3 CDs needed to be signed on the reverse. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist 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 were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). He said that he would refer people to their GP if they were not on a PPP and needed to be on one. And he would make a note on their medication record to reflect the referral.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. And short-dated items were clearly marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. 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, and two signatures were recorded. CDs were stored in accordance with legal requirements, and they were kept secure. The pharmacy's medicine fridge was suitable, and it was not over stocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. The records indicated that the temperatures were consistently within the recommended range. Some excess stock was being stored in the consultation room, including some prescription-only medicines and the room was not locked. The pharmacist said that he would ensure that the room was kept locked in future when it was not in use.

One of the pharmacy technicians said that uncollected prescriptions were checked regularly. People were often contacted after around six weeks to check if they needed the medicines before they were returned to stock. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed

prescriptions were checked frequently. People were given ‘owings’ notes when their prescription could not be dispensed in full, and the pharmacy kept them informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacy did not dispense medicines into multi-compartment compliance packs. The pharmacist said that these were dispensed at another pharmacy within the company. He explained the process and confirmed that people had consented for their medicines to be dispensed at a different pharmacy. The pharmacy managed ordering prescriptions on behalf of people and any 'when required' medicines were not routinely requested.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people’s signatures to help minimise the spread of infection. 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 NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. 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.

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. But it doesn’t always ensure that all the equipment it uses to count tablets is clean.

Inspector's evidence

Suitable equipment for measuring liquids and triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. The pharmacy had an electronic counter and one of the team said that the counter was not always accurate. There was a thick layer of powder residue inside the counter. A team member said that she would ensure that it was cleaned before next use and cleaned regularly after this. Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.