General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Earls Hall Pharmacy, 8 Earls Hall Parade, SOUTHEND-ON-SEA, Essex, SS2 6NW

Pharmacy reference: 1031409

Type of pharmacy: Community

Date of inspection: 28/11/2019

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. It receives around 85% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations and a needle exchange service. It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines. The people who use the pharmacy are mainly older people.

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	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. 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 to indicate that they had read and understood the SOPs. 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. And shelf edges were highlighted with 'check strength' stickers. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. And these were reported on the National Reporting and Learning System and recorded on the person's medication record. The pharmacist said that there had not been any recent incidents reported to the pharmacy. He said that all team members would be made aware about any.

There was limited workspace in the dispensary, but baskets were used to minimise the risk of medicines being transferred to a different prescription. And there was an organised workflow which helped staff to prioritise tasks and manage the workload. 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 trainee medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up in the morning, but she knew that she should not sell any medicines or hand out dispensed items until the pharmacist had arrived. The dispenser did not know that she should not carry out any dispensing tasks before the pharmacist had arrived. The inspector reminded her what she could and couldn't do if the pharmacist had not turned up.

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. And the emergency supply record was completed correctly. There were signed in-date Patient Group Directions available for the relevant services offered. And the 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 private prescription records were mostly completed correctly, but the prescriber's details and the appropriate date were not usually recorded. This could make it harder for the pharmacy to find these details if there was a future query. The right responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed correctly. The

pharmacist had not completed the log for the day of the inspection or for the previous day when the pharmacy was also open. He completed this during the inspection and confirmed that he would keep it up to date in the future.

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 carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were displayed in the shop window and were available on the NHS website. Results showed that 100% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed some safeguarding training provided by the pharmacy. The trainee MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist 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 trained team members to provide its services safely. They are provided with some training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. The team discusses adverse incidents and uses these to learn and improve. And 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, one trained dispenser and one trainee MCA working during the inspection. The dispenser had completed an accredited course for their role and the other team members were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The team members wore smart uniforms with name badges displaying their role.

The trainee 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He explained that he had recently attended a training say about the CPCS and he had undertaken training about sepsis and risk assessments. The pharmacist said that team members were not provided with ongoing training on a regular basis yet, but they did receive some. The dispenser had only worked at the pharmacy for around six weeks. She had access to the pharmacy's online training modules, but she had not yet completed any. The pharmacist said that team members would be able to complete training in the pharmacy during quiet periods in the future. They had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. He said that he felt able to take professional decisions.

Team members had yearly appraisals and performance reviews. They said that they felt comfortable about discussing any issues with the pharmacist or making any suggestions. There were no formalised meetings, but team members explained that information was passed on informally during the day.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that he carried out these services for the benefit of the people who used the pharmacy and he would not let the targets affect his professional judgement.

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. But the pharmacy could do more to keep some areas tidy and free from clutter.

Inspector's evidence

The pharmacy was secured from unauthorised access. 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 not available; the room temperature was suitable for storing medicines on the day of the inspection. There were many bagged items kept on the floor in the dispensary. The pharmacist said that he would reorganise the bagged items waiting collection and this would then allow these to be stored off the floor.

There were two chairs in the shop area for people to use. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy had a consultation room, but this was not easily accessible to wheelchair users. It was located towards the rear of the dispensary. On the day of the inspection, the room was being used to store recent deliveries and other items. The pharmacist said that he would ensure that these were moved to another area if the room was needed. A blind was available to cover the medicines which were on the way to the consultation room, and people’s personal information was not visible to people accessing the consultation room. The pharmacist said that people were taken through the dispensary and they were not left alone. 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, so that people get medicines and medical devices that are safe to use. It dispenses medicines into multi-compartment compliance packs safely. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was a small step up to the pharmacy with 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 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. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacy was in the process of carrying out an audit for people with diabetes, and it was due to start an audit for people taking methotrexate. The pharmacist said that the pharmacy supplied valproate medicines to a few people. He explained that he had spoken to people in the at-risk group who needed to be on the Pregnancy Prevention Programme, and this was recorded on their medication record. The pharmacy did not have the relevant patient information leaflets or warning cards available. The pharmacist said that he would order them from the manufacturer.

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 few months was marked. There were several expired items found with dispensing stock. The pharmacy was in the process of carrying out the date checking, but some medicines had expired at the end of September 2019. The pharmacist said that he would ensure that a more reliable date checking system was implemented. This would help to minimise the chance of out-of-date medicines being supplied to people.

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 pharmacist said that dispensed items were kept at the pharmacy until the prescription was no longer valid. There were a few items waiting collection and the prescription for these had expired. The pharmacist said that he would review the current system to help minimise the chance of items being handed out when the prescription was no longer valid. The trainee MCA knew that most prescriptions were valid for six months and knew that prescriptions for Schedule 3 CDs were only valid for 28 days. But she was not aware that prescriptions for Schedule 4 CDs were also only valid for 28 days. The pharmacist said that he already highlighted prescriptions for Schedule 3 CDs and he would extend this practice to include Schedule 4 CDs.

The pharmacist explained that people who had their medicines in multi-compartment compliance packs had assessments carried out by their GP, to show that the packs were needed. The pharmacy did not usually order prescriptions on behalf of people who received their medicines in these packs. The pharmacist explained that people contacted the pharmacy around one week before they were due to have their packs. The pharmacy kept a list so that people could be contacted and reminded if they had not ordered their prescriptions. 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 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 members of the pharmacy team. The pharmacist explained that this service was only provided for those people who could not collect their medicines from the pharmacy. 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. The pharmacist explained that the pharmacy would usually contact the person before attempting to deliver their items. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day.

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. But a record of any action taken was not always kept, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would ensure that any action taken was recorded in the future.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The pharmacist said that the equipment was not working properly. He confirmed that it would be used once it was in good working order. He had contacted the supplier and he said that team members had undertaken some training on how the system worked.

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. 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 shredder was in good working order. The phone in the dispensary was not portable, but it was at the rear of the pharmacy so conversations in the dispensary could not be heard in the shop area.

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.