General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Howells & Harrison (Southend) Ltd., 235 Woodgrange Drive, Thorpe Bay, SOUTHEND-ON-SEA, Essex, SS1 2SG

Pharmacy reference: 1031431

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area, and it is near to a large seaside town. 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 and a stop smoking service. It also provides medicines as part of the Community Pharmacist Consultation Service. And it provides the Electronic Medicines Optimisation Pathway service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines.

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 largely protects people's personal information and it regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people. It keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. But the pharmacy doesn't always review the 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 identified and managed the risks associated with its activities. There were documented, up-to-date standard operating procedures (SOPs) available. Team members had signed to show that they had read, understood and agreed to follow 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, but these had not been reviewed for any patterns since May 2019. 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 where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong item had been supplied to a person. The person had realised the mistake before using the item. They had returned it to the pharmacy and was given the correct one.

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 pharmacy technician said that the pharmacy would open if the pharmacist had not turned up in the morning. She said that she would attempt to contact the pharmacist and display a notice informing people that there was no pharmacist on duty. The dispenser knew that she should not carry out any dispensing tasks if there was no responsible pharmacist (RP). The dispenser knew that she should not sell any pharmacy-only medicines or hand out any dispensed items if the pharmacist was not in the pharmacy.

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 private prescription records and emergency supply records were completed correctly. 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 right RP notice was clearly displayed and the RP record was largely completed correctly. There were alterations made to the RP record. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query.

Confidential waste was removed by a specialist waste company, 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 be viewed by people using the pharmacy, but people's personal information could not be seen from the shop area. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were displayed in the shop area and were available on the NHS website. The 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 pharmacy technician said that there had not been any recent complaints.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and she would refer any concerns to the pharmacist. The pharmacy technician said that there had not been any recent 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 do the right training for their roles. And 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 have regular meetings. 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.

Inspector's evidence

There was one regular pharmacist, one pharmacy technician, one trained dispenser and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. 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 and the workload was well managed.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she 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 and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacists and pharmacy technician had undertaken training about ‘look alike and sound alike’ medicines provided by the CPPE. The pharmacy technician and pharmacist had also undertaken training about risk management and sepsis. Team members had undertaken training about the Community Pharmacist Consultation Service, including how the information should be entered on the computer system. The pharmacy technician said that an electronic tablet was available with some training modules, but these were mostly for the medicines counter staff. The dispenser said that learnings from training courses had been shared with the team if she felt that they may also benefit from it.

The pharmacist explained that the pharmacy held meetings before the implementation of the CPCS to ensure that all team members understood how the system worked. The pharmacy also had a meeting about the Electronic Medicines Optimisation Pathway before implementation to ensure that team members knew what action to take when the discharge letters were received from the hospitals.

The pharmacy technician said that the business manager from Alphega attended the pharmacy every six weeks. She explained that he held training sessions with team members and he also carried out some role playing at the medicines counter. The dispenser said that team members had ongoing informal performance reviews, but these were not documented. The pharmacy technician said that there were plans to re-implement the formalised appraisal and performance reviews. And these would be carried out by the business manager.

The pharmacist said that he felt able to take professional decisions. Team members felt comfortable about discussing any issues with the pharmacy technician, pharmacists or the superintendent

pharmacist. Targets were not set for team members. The pharmacist said that the services were carried out 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 pharmacists area and he could hear conversations at the counter and could intervene when needed. Air conditioning was available; the room temperature was suitable for storing medicines.

Some bags of dispensed medicines were not kept securely at the start of the inspection. The pharmacy technician moved these during the inspection and they were then kept on a shelving unit behind the medicines counter. The pharmacy-only medicines which were kept on that shelving until were moved to where the dispensed items had been previously kept next to the medicines counter. The pharmacist printed a notice and said that this would be displayed to request that people ask for assistance if they wanted those medicines. The pharmacy technician said that the pharmacy was due to undergo a refit in the near future. There was a small bench in the shop area for people to use. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was located next to the medicines counter. It was small and could be accessed from behind the medicines counter and from the dispensary. A wheelchair would fit in the room, but only if the chair was removed and having the wheelchair in the room would leave very little room for any movement of people. It was well-screened and 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 and these were clean.

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. People with a range of needs can access the pharmacy's services. 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.

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 pharmacy technician said that prescriptions for higher-risk medicines were sometimes highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. 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 highlighted. This helped to minimise the risk of these medicines being supplied when the prescription was no longer valid. The pharmacy technician 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 updated versions of the relevant patient information leaflets or warning cards available. The pharmacy technician said that she would request 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 six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Lists of the short-dated items were kept so that these could be removed from dispensing stock before the items had expired.

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. If people did not have their 'owings' notes with them when they collected their medicines, they were asked to sign the pharmacy's copy to show that they had collected their medicines The pharmacy technician said that uncollected prescriptions were checked regularly and people were contacted after around three months to ask if they needed their items. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. The pharmacy technician said that the person's medication record was updated.

The pharmacist said that people who had their medicines in multi-compartment compliance packs had assessments carried out by their GPs to show that they needed the packs. The pharmacy technician said

that she had attended a meeting with the local surgery and a pharmacist from the Clinical Commissioning Group to discuss the people who had their medicines in these packs. She said that this had highlighted some people who potentially did not need to have their medicines in the packs and some people who needed to have blood tests because of the medicines they were taking. The dispenser said that one of the dispensers managed the packs and ordered the prescriptions for these, but other team members could do this in her absence. 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 the dispenser who managed the packs contacted people to see if 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. 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. The pharmacy technician said that she thought that there were multiple people's details on each sheet so the layout might make it harder to ensure that people's details were protected when signatures were recorded. She said that she would check with the delivery driver when they were next at the pharmacy to ensure that other people's personal information was protected when signatures were recorded. 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 pharmacy technician explained the action the pharmacy took in response to any alerts or recalls. But no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response. The dispenser said that she would keep a record of any action taken using the email system in the future.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not being used. The pharmacy technician said that the superintendent pharmacist had discussed the implementation with the team, but they had not yet received any training on how the equipment 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. A spatula was available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. 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 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.