

Registered pharmacy inspection report

Pharmacy Name: Chrystalls Chemist, 12 The Broadway, WOODFORD GREEN, Essex, IG8 0HL

Pharmacy reference: 1031454

Type of pharmacy: Community

Date of inspection: 10/08/2022

Pharmacy context

The pharmacy is located within a parade of shops close to a station. The pharmacy provides a range of services, including the New Medicine Service and flu vaccinations. It also 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

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

The pharmacy's working practices are generally safe and effective. People who use the pharmacy can give feedback on its services. The pharmacy mainly keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process.

Inspector's evidence

Standard operating procedures (SOPs) were available, these had not been reviewed for some time. The last recorded review was in February 2018. The pharmacy manager explained that these were due to undergo review. Team members had read and signed SOPs relevant to their roles. The team had been routinely ensuring infection control measures were in place.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were seen to be consistently recorded. When near misses occurred the responsible pharmacist (RP) had a discussion with the team member to discuss what had happened and what could be done differently to avoid reoccurrence. Dispensing errors were investigated and recorded in a book. The RP would also complete a root cause analysis. Team members were briefed to take care when dispensing medicines that looked or sounded alike. When the RP had first started working at the branch he had rearranged all the shelves and arranged medicines alphabetically to make dispensing safer.

A correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure and prior to the pandemic, annual patient satisfaction surveys had been completed. These had not been restarted at the time of the inspection.

Records for emergency supplies and unlicensed medicines dispensed were well maintained. Private prescription records were kept electronically and they were also generally well maintained but the prescriber details recorded on some of the entries were missing. RP records were well maintained but some pharmacists were not routinely signing out, which could make it harder for the pharmacy to show who the RP had been if there was a query. Controlled drug (CD) registers seen generally complied with requirements, however, there was some over-writing in the methadone registers and the location of wholesalers was missing from some entries. CDs that people had returned were recorded as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register.

Assembled prescriptions were stored in the dispensary and people's private information was not visible to others using the pharmacy. An information governance policy was available and team members had completed training and were briefed from time to time. Relevant team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR) and consent to access these was gained verbally.

Pharmacists had completed level two safeguarding training and the pharmacy manager had also completed training. Contact details for safeguarding boards were available. Team members had been

verbally briefed and the pharmacy manager gave an assurance that he would look into safeguarding courses available for support staff.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the RP, who had started working at the branch since February 2022. And the pharmacy manager, who was a trained medicines counter assistant (MCA) and also one of the company's directors. And a full-time trained dispenser. The superintendent pharmacist (SI) who usually worked on Saturday also came in during the inspection. Other team members who were not present included two trained MCAs. The RP felt that there were enough staff. There were a number of prescriptions waiting to be checked, but the RP said that this was part of his workload and people would be sent a message when their prescription was ready to collect.

Staff performance was managed by one of the directors with appraisals carried out every six months. And pharmacists usually provided team members with feedback if there was a problem of something was not done correctly. The pharmacy manager was observed counselling people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. He would only sell one pack of most medicines and check with the pharmacist for multiple requests.

Team members were provided with training material as it was received. The RP also briefed the team on any training he completed and forwarded information he received. The SI also forwarded information to the teams. Recently team members had been sent information about Vagifem changing classification from prescription only to available to buy over the counter. Some companies also provided training for team members.

Team members discussed issues as they arose. Team members felt able to share suggestions, concerns and feedback with the directors of the company. The pros and cons of any new suggestions were taken into consideration and then next steps taken based on these. There were no numerical targets set for the teams.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the pharmacy's services. But the pharmacy could do more to ensure that its premises always protects people's private information.

Inspector's evidence

The pharmacy was clean. The front of the shop and retail area were original vintage fittings. The dispensary was small but had ample workbench space. However, workbenches were covered with prescriptions waiting to be checked. A sink was available for the storage of medicines. Cleaning was carried out by the team on a regular basis.

The pharmacy had a consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. Not all confidential information inside the room was properly secured. When this was highlighted, the pharmacy manager provided an assurance that this would be moved out of the room into an area inaccessible to the public. The room temperature was adequate for the provision of pharmacy services and the safe storage of medicines. The premises were secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised. It orders its medicines from reputable sources and largely manages them properly. Team members do not always refer to the prescription when it is assembling compliance packs. And this could increase the chance that a mistake is made.

Inspector's evidence

The pharmacy was easily accessible, it was situated at street level and there was easy access to the medicines counter. The pharmacy had the ability to produce large print labels. Some team members were multilingual. A delivery service was available.

Most prescriptions were received by the pharmacy electronically. These were printed out in batches and organised as to when they were due. The forms were left in a basket and processed and dispensed by the dispenser. Prescriptions were checked by the pharmacist and people were sent a text message when their medicines were ready to collect. Medicines which were kept in the fridge were dispensed when people came to collect their prescription. It was rare that the pharmacists had to self-check. The RP described taking a mental break in between dispensing and checking a prescription in the event that he had to. Dispensed and checked-by boxes were available on labels which were observed to be used. Baskets were used to separate prescriptions, preventing transfer of items between people.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Additional checks were carried out when people collected medicines which required ongoing monitoring. The RP verbally checked if people were having regular blood tests if they did not have their records with them. The team did not record the information obtained.

Some people's medicines were supplied in multi-compartment compliance packs. One of the local surgeries had set up a system where prescriptions were sent to the pharmacy on a weekly basis. For other surgeries prescriptions were ordered on a monthly basis. The dispenser checked all prescriptions for changes as they were received. If a change was identified the prescription was flagged to the RP. Individual records were kept for each person. New record sheets were prepared in the event of any changes. The dispenser prepared a few packs using the record sheets in advance of receiving the prescriptions. Once the prescriptions were received the dispenser completed a check and then passed on the prepared pack with the prescription to the RP for a final check. The RP did not check packs if a prescription was not available. Packs were sealed as soon as they were prepared. The dispenser agreed to speak to the surgery to request if prescriptions could be ordered earlier to ensure prescriptions were available in advance of packs being prepared. Assembled packs were labelled with product descriptions. Mandatory warnings were missing and the team provided an assurance that they would speak to the pharmacy's IT helpdesk to change the settings. Patient information leaflets (PILs) were not routinely supplied, the dispenser agreed to ensure these were provided monthly. There was also an incomplete audit trail to show who had prepared the packs. This could make it difficult to investigate who was involved in the event that something went wrong.

Deliveries were carried out by the pharmacy manager. Signatures were no longer obtained when medicines were delivered and this was to help infection control. In the event that someone was not

available, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were organised on shelves in a tidy manner. Fridge temperatures were monitored daily and recorded. However, there was a considerable build-up of ice seen in the fridge. Some packs of medicines were also seen to be stuck to the back of the fridge. The RP provided an assurance that he would check with the manufacturer's if these were safe to use. At the time of the inspection the minimum and maximum temperatures from the probe were outside of the required range. But the current temperature checked during the inspection was 5 degrees Celsius, which was within the appropriate range. The previous temperature records were observed to be within the required range for the storage of medicines. The pharmacy manager explained that the fridge had been replaced after the previous inspection and there was a spare fridge available on the premises. Following the inspection, the pharmacy confirmed that they had ordered a replacement fridge, and were monitoring temperatures and using the spare fridge that was available. CDs were held securely.

A number of deblistered tablets were found stored in a basket in brown bottles and some in their original packs. All the medicines stored in the brown bottles seen were not labelled with expiry dates or batch numbers. This could make it difficult to identify medicines in the event that there was a recall. These medicines were disposed of by the RP during the inspection.

Expiry-date checks were carried out every three months. Shelves were divided into sections which were labelled. Stickers were used to highlight short-dated medicines. No date-expired medicines were found on the shelves checked. A date-checking matrix was available but this had last been updated in February 2022. Out-of-date and other waste medicines were kept separate from stock and generally stored securely until collected by licensed waste collectors. Drug recalls were received via email. The RP described how in the branch he worked at previously these were printed and filed. The RP had not seen any alerts recently. The Medicines and Healthcare products Regulatory Agency (MHRA) subscription for receiving alerts for drug recalls was discussed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Glass measuring cylinders and tablet and capsule counting equipment were clean and ready for use. A separate tray was available and used for cytotoxic medication and separate measures were used for liquid CDs to avoid cross contamination.

A blood pressure monitor was available which was used as part of the services provided. Team members were unsure of calibration arrangements but the RP said the machine was fairly new. A fridge of adequate size was available. Up-to-date reference sources were available including access to the internet.

Confidentiality was generally maintained through the appropriate use of equipment and facilities. The computer in the dispensary was password protected and out of view of patients and the public. Confidential waste was separated and collected by a third-party shredding company.

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.