General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Longthornes Chemist, 5 West Road, WESTCLIFF-ON-SEA, Essex, SS0 9AU

Pharmacy reference: 1031470

Type of pharmacy: Community

Date of inspection: 21/04/2021

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area, serving a mixed population. The pharmacy provides a range of services, including the New Medicine Service and a needle exchange service. The pharmacy supplies medications in multi-compartment compliance packs to several people who live in their own homes to help them manage their medicines. And to one medium sized care home. It also provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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. Team members understand their role in protecting vulnerable people. And people can provide feedback about the pharmacy's services. The pharmacy largely protects people's personal information. It keeps the records it needs to keep by law and these are mostly accurate. 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. Up-to-date standard operating procedures (SOPs) were available. Team members had signed to show that they had read, understood and agreed to follow the SOPs. The pharmacy had carried out workplace risk assessments in relation to Covid-19. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses had not been recorded recently. The pharmacist said that he would print a new log and encourage team members to record their own mistakes. These would then be reviewed 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. But there were some medicines in one stack which were different strengths. This may increase the chance of the wrong items being selected. The pharmacist said that he would ensure that the stock was better organised in future. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where some medication had been supplied to the wrong person. The incorrect label had been added to the outside of the bagged items. Team members were made aware and instructed to pay better attention when bagging items in future.

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 would remain closed if the pharmacist had not turned up. Team members would attempt to contact the pharmacist and would call the superintendent pharmacist if needed. The team knew that they should not carry out any dispensing tasks until there was a responsible pharmacist (RP). They knew that they should not sell any pharmacy-only medicines or hand out bagged items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Other records largely complied with the requirements. But the nature of the emergency was not

routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. The private prescription records were mostly completed correctly, but the prescriber's details were not routinely recorded. Not all the necessary information was consistently recorded when a supply of an unlicensed medicine was made. Not keeping accurate records of supplies could make it harder for the pharmacy to find these details if there was a future query.

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.

The pharmacy had not carried out a patient satisfaction survey for the previous year and this was due to the pandemic. Results from the most recent survey were available on the NHS website and were mostly positive. The complaints procedure was available for team members to follow if needed. And team members would refer any complaints to the pharmacist on duty. There had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had undertaken some safeguarding training, either provided by the pharmacy or within the dispenser course. The trainee dispenser 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 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 team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to help support their learning needs and maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular full-time pharmacist, one trained dispenser and two trainee dispensers working during the inspection. Some team members had completed an accredited course for their role and the rest were undertaking training. The team worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispenser appeared confident when speaking with people. She explained that she would refer to the pharmacist before selling any pharmacy-only medicine or if someone 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. And he had recently undertaken some training provided from an external training provider, including about Covid-19.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. Information was passed on informally during the day. The pharmacist explained that the workload during the pandemic had not allowed team members to take time during the day to complete any training. And team members were expected to undertake the training modules in their own time. He planned to allow some time each week in the near future, once the work pressures were reduced.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They explained about the informal performance review process where the pharmacist would address any concerns with them at the time. There were no formalised team meetings, but information was discussed and tasks allocated where needed. The pharmacist felt able to take professional decisions and would refer any concerns to the SI. There were no formal targets set for team members. And services were provided for the benefit of people using 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. 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. It was bright, clean and most areas were generally tidy. 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; the room temperature was suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

A large screen had been installed at the medicines counter and covered the entire width of the counter. This helped to protect people from the spread of infection. Only two people were allowed in the shop area at a time and there were two chairs available in the shop area for people to use. These were positioned at a suitable distance from each other.

There were some bagged items kept on the floor in the dispensary and this made the dispensary look untidy. The pharmacist said that he would make room on the retrieval shelves for these items. Some people’s personal details were potentially visible on some bagged items. The pharmacist explained how he would change the way these were stored so that the information was protected.

The pharmacy's main consultation room was accessible to wheelchair users and was accessible from the shop area. It was suitably equipped and well-screened. The room was not kept locked when not in use, but there were no items in the room which needed to be kept secure. Low-level conversations in the consultation room could not be heard from the shop area. There was a hatch from the consultation room to the dispensary. This allowed people additional privacy while being served.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls.

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. People returning used sharps were asked to place the containers directly into a suitable bin which could be accessed at the hatch between the consultation room and the dispensary. This meant that team members did not have to handle the containers.

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 usually handed out by the pharmacist. So, he had the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. 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. The relevant patient information leaflets were not available at the time of the inspection. The pharmacist said that he would order replacements from the manufacturer. Warning cards were attached to the packaging that the medicines were in.

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 were marked. There were no date-expired items found in with dispensing stock. Several medicines were found which were not kept in their original packaging. Not keeping the medicines in their original packaging could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The team said that they would ensure that medicines were stored properly in future.

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. Uncollected prescriptions were checked regularly and items left uncollected after three months were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

Assessments had been carried out by people's GP to show that they needed their medicines in 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; people usually contacted the

pharmacy when 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. 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. But patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that the patient information leaflets were supplied with the medicines each month. Packs were largely labelled with all the relevant information. But the additional cautionary and advisory labels were not printed on the backing sheets. The pharmacist said that he would contact the software provider so that these appeared in future. The care home was responsible for ordering prescriptions for their residents. This was done via the pharmacy and any changes were highlighted to the pharmacist.

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, and two signatures were recorded.

Deliveries were usually made by a delivery driver. Other team members made the deliveries when the driver was not working. 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. But any action taken was not recorded and kept for future reference. This may make it harder 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.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean. Separate ones were used to measure certain medicines to help minimise the change of cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. Personal protective equipment was available for team members. They were all wearing masks during the inspection and were using hand sanitiser.

The pharmacist said that fridge temperatures were checked daily, and that the maximum and minimum temperatures were recorded. Records on the computer indicated that the previous temperatures were consistently within the recommended range. But, the thermometer for the fridge in the dispensary was showing a maximum temperature of 11 degrees Celsius and a minimum of minus six degrees Celsius. The current temperature was six degrees Celsius. This was discussed with the pharmacist and he provided assurance that the thermometer would be reset after each time it was checked and that any anomalies would be investigated. The fridges were suitable for storing medicines and were 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.