General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Longfield Pharmacy, The Annexe, Longfield Surgery, Princes Road, MALDON, Essex, CM9 5DF

**Pharmacy reference:** 1084910

**Type of pharmacy:** Community

**Date of inspection:** 06/10/2022

## Pharmacy context

The pharmacy is located next to a surgery a busy high street in a town centre in a largely residential area. It provides a range of services, including the New Medicine Service and the flu vaccination service. It also provides medicines as part of the Community Pharmacist Consultation Service. 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. The pharmacy receives most of its prescriptions electronically.

## Overall inspection outcome

**Standards not all met**

**Required Action:** Improvement Action Plan

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 not all met | 2.2 | Standard not met | The pharmacy does not always ensure that its team members are undergoing training appropriate for their role within the required timeframe. |
| **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. And team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information. And it generally keeps its records up to date and accurate. The pharmacy 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 had up-to-date standard operating procedures (SOPs). 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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. There was a near miss record available to use but it was not always used when a mistake happened. The pharmacist said that he would encourage team members to record their own mistakes and then he would review the record for any patterns in future. Team members said that there were very few mistakes made due to the dispensing robot being used for the majority of the workload. 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 a medicine with a short expiry date had been given to a person. Team members were reminded to check that the medicines had a long enough shelf life for the full course.

Workspace in the dispensary was free from clutter. An organised workflow helped staff to prioritise tasks and manage the workload. Team members used baskets to help minimise the risk of medicines being transferred to a different prescription during the dispensing process. And they initialled 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. One of the dispensers said that she would contact the superintendent pharmacist if the responsible pharmacist (RP) had not turned up in the morning. And she knew which tasks she should not carry out if there was no RP signed in. Team members knew which tasks should not be carried out if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. And there were signed in-date patient group directions available for the relevant services offered. The private prescription records were largely completed correctly, but the correct prescriber details were not always recorded. And this could make it harder for the pharmacy to find these details if there was a future query. 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. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was not the same as the physical amount of stock available. The pharmacist said that the superintendent (SI) pharmacist had recently carried out a destruction of expired CDs, but the registers had not yet been updated. He said that he would speak with the SI and ensure that this was done promptly. The right RP notice was clearly displayed and the RP record was largely completed correctly. But there were several occasions where the pharmacist had not signed out

when they had finished their shift and a different pharmacist had worked the following day. The pharmacist said that he would ensure that the pharmacy records were completed correctly in future.

Bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Some team members used their own NHS smartcards during the inspection, but not all team members had their own smartcards. Team members said that these were sometimes shared or left at the pharmacy so that other team members could use them on days when they were not working. Team members said that they would discuss this with the SI and request that they each have their own smartcards.

The pharmacy had not carried out a patient satisfaction survey since the start of the pandemic. The complaints procedure was available for team members to follow if needed. The team were not aware of any recent complaints. And the pharmacy manager said that they would inform the SI about any complaints received.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. One of the dispensers said that he had undertaken some training about safeguarding before starting work at the pharmacy. And he knew which people could potentially be classed as vulnerable. He would refer any concerns about a vulnerable person to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy does not always enrol its team members on accredited pharmacy courses in a timely manner. And this makes it harder for the pharmacy to demonstrate that they have the skills and knowledge they need to provide the services safely. However, the pharmacy has enough team members to provide its services. Team members can to raise concerns to do with the pharmacy or other issues affecting people's safety. They do some ongoing training, but this is not regular or structured. This could make it harder for them to keep their skills and knowledge up to date.

### Inspector's evidence

There was one pharmacist, two trained dispensers and one trainee dispenser. There were also two team members who had not enrolled on an accredited course. One of these team members was covering in the dispensary on the day of the inspection and undertaking tasks such as unpacking the stock deliveries. The other team member was working on the medicines counter. One of the team members had worked at the pharmacy for around five months and the other for around three months. And they had not been enrolled on suitable courses for their role. Another team member working on the day of the inspection had temporarily returned to work at the pharmacy to help out. She was undertaking tasks such as unpacking stock deliveries and loading the medicines into the dispensing robot. She had previously worked at the pharmacy for over three months and had also not been enrolled on an accredited course. During the inspection the team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was managed.

A team member working on the medicines counter appeared confident when speaking with people. She said that she would refer to the pharmacist if a person asked to purchase more than one box of medicine. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked relevant questions 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 done the updated flu vaccination and COVID vaccination training. He said that he had completed declarations of competence and consultation skills for the services offered. He felt able to take professional decisions. The pharmacist said that the team members were not provided with ongoing training on a regular basis, but they did receive some. And this was on an ad-hoc basis when he thought that there was important information about a medicine which needed to be passed on.

The pharmacist said that team members had informal ongoing performance reviews but these were not documented. One of the dispensers said that there were formalised and documented reviews yearly before the pandemic. Team members felt comfortable about discussing any issues with the pharmacist or SI. Targets were not set for team members. The pharmacist said that 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.

### 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 were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. There were some items left unsecured in the consultation room. These were brought to the attention of the pharmacist and he said that he would ensure that these were kept secured in future. Toilet facilities for staff were available in the surgery next door. These were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

## Principle 4 - Services ✔ Standards met

### Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls which helps make sure that its medicines and devices are safe for people to use.

### 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 pharmacist said that prescriptions for higher-risk medicines such as warfarin and methotrexate were highlighted. So that he had the opportunity to speak with these people when they collected their medicines. He explained that he would check that they were having relevant blood tests at appropriate intervals. But a record of blood test results was not kept at the pharmacy. One of the dispensers explained that the surgery would only usually issue a person with seven days' supply of their medicines if they were due to have a blood test. Prescriptions for Schedule 3 and 4 CDs were not highlighted. One of the team members involved with handing out dispensed items was not aware that prescriptions for these items were only valid for 28 days. She explained that she would ask the person to confirm their name and address before handing out the bagged items. But she would not check the validity of the prescription. And this could increase the chance of these medicines being supplied when the prescription is no longer valid. There was a prescription found which had expired a few days before the inspection. 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 pharmacy did not have the warning sticker or additional copies of the warning cards available. The pharmacist explained that the pharmacy only dispensed whole packs of these medicines so all of the relevant warnings would be given each time the medicine was dispensed. Team members were made aware that the warning cards on some packs could be removed to allowed room to attach the dispensing label. The pharmacist said that he would ensure that the additional warning stockers and warning cards would be requested from the manufacturer.

Stock was stored in an organised manner in the dispensary. Most of the medicines were stored in the dispensing robot. Expiry dates were checked regularly and this activity was recorded. Items not in the robot due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock. The robot let team members know when items were due to expire and this showed on the computer screens. One of the dispensers said that the screens were checked regularly and items were usually removed before they 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 for 'owings' which were due to be delivered to people when dispensed were kept separated from ones which were due to be collected. This helped to ensure that these prescriptions were not misplaced. A list of prescriptions requested from the surgery was kept. Prescriptions were kept at the pharmacy until

the remainder was dispensed and collected. This made it easier for team members to refer to the original prescription while dispensing which helped to minimise the chance of errors. One of the dispensers said that that uncollected prescriptions were checked every two or three months. Any items remaining uncollected after this amount of time were returned to dispensing stock where possible. And the prescriptions would be returned to the NHS electronic system or to the prescriber. There were a few prescriptions found waiting collection which were no longer valid. The pharmacist and he said that he would ensure that a more reliable system was implemented to help minimise the chance of medicines being handed out when the prescription was no longer valid.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. 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. One of the dispensers said that most people were responsible for ordering their prescriptions from their GP. 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. 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, and two signatures were recorded.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures and this was 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. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The driver had a cool bag to help keep medicines at a suitable temperature. He explained that he attempted to deliver temperature-sensitive items first and would return these promptly to the pharmacy if he was not able to deliver them. The pharmacy kept a list so that people could be informed that their items were with the delivery driver if they contacted the pharmacy.

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 that the superintendent pharmacist or the pharmacy manager usually ensured that the necessary action was taken in response to any alerts or recalls. He was not sure if a record of any action taken was kept which could make it harder for the pharmacy to show what it had done in response. He said that he would ensure that this was done in future.

## 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 and triangle tablet counters were available and clean. A separate measure was marked for use with certain liquids only and this helped avoid any cross-contamination. 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. Fridge temperatures were checked daily and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. And 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. |