General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Elora Pharmacy, 115/117 High Road, South Benfleet, BENFLEET, Essex, SS7 5LN

**Pharmacy reference:** 1087469

**Type of pharmacy:** Community

**Date of inspection:** 11/07/2019

## Pharmacy context

The pharmacy is located on a busy high street in a town centre surrounded by residential premises. The people who use the pharmacy vary widely in age. The pharmacy receives around 85% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and a stop smoking service. The pharmacy provides multi-compartment compliance aids to around 30 to 40 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to one person. It supplies medicines to a 54 bed nursing home.

## 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 largely identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. It largely keeps its records up to date. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. The pharmacist said that the standard operating procedures (SOPs) were in the process of being reviewed. These had been available to view previously. But the pharmacist said that they had been temporarily removed from the pharmacy and would be brought back soon. Not having SOPs available at the pharmacy could make it harder for team members to refer to them if they needed to. Following the inspection, the pharmacist confirmed that the SOPs had been returned to the pharmacy the following day. The pharmacy had reliable near miss reporting and review processes. 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 on the log by the person who had made the mistake. The pharmacist said that he reviewed the log regularly for any patterns. Medicines which looked alike or sounded alike were separated where possible. The pharmacist said that dispensing incidents would be recorded on a designated form and a root cause analysis was undertaken. He said that there had not been any dispensing incidents reported to the pharmacy for several years.

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. The dispensing robot applied dispensing labels to the medicines before these were ejected. The pharmacist said that this had helped to reduce the number of selection errors.

The medicines counter assistant (MCA) said that the pharmacy would remain closed if the pharmacist had turned up. She confirmed that she would not sell pharmacy only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The dispenser said that she would carry out dispensing tasks before the pharmacist had turned up. The inspector reminded them what they 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 special was made. The private prescription record was completed correctly. But a supply had been made against a prescription which was not written on the correct form. The emergency supply record was completed correctly.

Controlled drug (CD) running balances were checked around once a month and at the time of supply or receipt. Liquid CD balances were checked monthly; overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The

responsible pharmacist (RP) record was largely completed correctly. But there were a few recent occasions when the pharmacist had not completed the RP log when they finished their shift and a different pharmacist was responsible the following day. The correct RP notice was not displayed at the start of the inspection. The pharmacist changed the notice so that his details were displayed.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own Smartcards during the inspection. Dispensed items awaiting collection could not be viewed by people using the pharmacy. Team members had completed General Data Protection Regulation (GDPR) training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results showed that over 97% of respondents were satisfied with the pharmacy overall. The pharmacist said that he was not aware of any recent complaints. The complaints procedure was displayed in the shop area.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist. The pharmacist said that there had been a concern raised by a team member, about a person who used the pharmacy. The dispenser said that the concern had been passed to the pharmacist who had spoken with the person's GP. 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 help keep their skills and knowledge up to date. They can raise any concerns or make suggestions and have meetings. This means that they can help improve the systems in the pharmacy.

### Inspector's evidence

There was one pharmacist (one of the owners), two dispensers and one MCA working during the inspection. 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 MCA appeared confident when speaking with people. She referred to the pharmacist when asked by the inspector if she could sell two boxes of pseudoephedrine containing products. The pharmacist said that this was allowed but only if he knew the person and had checked what other medicines they were taking. And the till would allow two boxes to be sold. The pharmacist said that he would contact the software provider to add the warning that only one box should be sold and he would inform all other team members of this. She said 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.

All team members working in the dispensary had completed an NVQ level 2 dispenser course or were enrolled on an accredited dispenser course. The MCA had completed an accredited counter assistant course. She said that she received regular training, but this was not recorded. A training folder was available but the training record sheet had not been completed since 2016. The pharmacist said that he would ensure that the training log was kept up to date. He said that team members were provided with protected training time. This meant that they were able to complete this training at work. The pharmacist was an independent prescriber. And he said that he had completed all required training for the services offered. And this included declarations of competence and consultation skills training.

The pharmacist said that there were meetings held when needed to discuss any issues. All team members were encouraged to attend and the meetings were held when the pharmacy was closed. The dispenser said that she felt confident to discuss any issues with the pharmacist. She said that one of the team members had suggested keeping excess stock in alphabetical order. She confirmed that this had been changed and it was now easier for team members to find medicines. The dispenser said that he had informal appraisals and performance reviews with the pharmacist. But the pharmacist said that these were not documented. He said that this was something he would consider for future reviews. The pharmacy had a meeting with the surgery practice manager and the clinicians every six months. There were to discuss any issues and how to improve systems and communication between the pharmacy and the surgery. Targets were not set. The pharmacist said that services were provided for the benefit of the 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.

### 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. An extendable barrier was used to restrict access behind the counter to unauthorised people. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. The pharmacist said that the door to the surgery was closed when the surgery was closed. A shutter was used over this door to restrict access and this could only be operated by the pharmacy.

Air-conditioning was available; the room temperature was suitable for storing medicines. A counter to the rear of the dispensary was used to serve people taking substance misuse medicines. This area gave them added privacy while collecting their medicines. There were two chairs in this area for people to use if needed. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

There was additional seating available in the surgery next to the pharmacy. This could be accessed via the steps or a ramp between the pharmacy and the surgery.

The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. 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

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This 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 via an automatic door. Team members had a clear view of the main entrance from the medicines counter. Services and opening times were clearly advertised. And a variety of health information leaflets were available. An induction hearing loop was available. But it was not charged. The pharmacist said that he would find the charger and ensure that this was in good working order.

The pharmacist said that he sometimes checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. And kept a record of some blood test results. He said that he would keep records more frequently of checks made so that it would be easier for the pharmacy to check that the person was having relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted and these were handed out by the pharmacist. So, there was the opportunity for the pharmacist to speak with these people when they collected their medicines. Prescriptions for schedule 3 CDs were clearly highlighted. Team members knew that these prescriptions were only valid for 28 days. Prescriptions for schedule 4 CDs were not highlighted. And some team members did not know how long these prescriptions were valid for. The pharmacist said that he would highlight these prescriptions to help minimise the chance of these medicines being handed out when the prescription was no longer valid. The MCA said that CDs and fridge items were checked with people when handing them out. She confirmed that she checked with the pharmacist before handing these items out. The pharmacist said that the pharmacy supplied valproate medicines to a few patients. 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 patient information leaflets or warning cards available. The pharmacist said that he would order more from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly and this activity was recorded. Stock due to expire within the next seven months was marked. Lists were kept for short-dated items. Items were removed from dispensing stock at least one month before they were due to expire and disposed of appropriately. The pharmacist said that the dispensing robot was used for 'fast moving' medicines. He said that the new software installed should be able to automatically record the expiry date of a medicine when they were put into the robot. He said that reports were printed to identify items which had not been used recently. These were removed from the robot and kept in the dispensary. There were no date-expired items found in with dispensing stock. Medicines were kept in appropriately labelled containers.

The dispenser said that part-dispensed prescriptions were checked daily and 'out-of-stock' items were checked with suppliers weekly. '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 items were dispensed. The dispenser said that uncollected prescriptions were checked monthly. She confirmed that items uncollected after around three months were returned to dispensing stock where possible. Prescriptions were not usually kept with the dispensed medicines until the items were collected. This could make it more difficult for team members to know if the prescription was still valid when the medicines were handed out. The pharmacist said that he would ensure that prescriptions were kept at the pharmacy until the medicines were collected.

Prescriptions for people receiving their medicines in compliance aids 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 dispenser said that people usually ordered these when they needed them. The pharmacy kept a record for each person which included any changes to their medication. They also kept hospital discharge letters for future reference. Compliance aids were suitably labelled and there was an audit trail to show who had dispensed and checked each compliance aids. Patient information leaflets (PILs) were routinely supplied.

The pharmacist said that the nursing home was responsible for ordering prescriptions for their residents. He confirmed that prescriptions were sent to the nursing home when the pharmacy received them. So that the staff at the nursing home could check that prescriptions had been received for all items ordered. He said that people were given the choice of which pharmacy they wanted their prescription to go to. He confirmed that the pharmacy provided administration charts for each person in the nursing home to help with the safe supply of medicines. The pharmacist said that another pharmacist who worked at the pharmacy visited the nursing home regularly to carry out medication audits. He said that he had arranged for a pharmacist from the NHS to visit the nursing home. So that there were independent checks carried out by someone who was not involved with the nursing home or pharmacy.

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 when received by the pharmacy 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 on a hand-held electronic device. These were recorded in a way so that another person's information was protected. The pharmacy could view the delivery log and check when items had been delivered and who had signed for them. Failed deliveries were returned to the pharmacy before the end of the working day. A card was left at the address instructing the patient to contact the pharmacy to rearrange delivery. The driver said that he attempted to deliver medicines requiring refrigeration at the start of his delivery round. And all deliveries were within the local area.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

The pharmacy had the equipment installed for the EU Falsified Medicines Directive. The pharmacist said that the pharmacy had been scanning some medicines but there were not many which had the 2D barcode on. Team members had received some training and the pharmacist said that he had written a procedure for the process.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Triangle tablet counters were available and clean. The dispenser said that methotrexate was in foil packs. The dispenser said that the electronic counter was calibrated before each use. He explained how this was done. The containers were marked ‘un-coated’ and ‘coated’ and these were clean. This helped avoid any cross-contamination.

The pharmacist said that the blood pressure monitor was replaced yearly. And the carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. 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. The pharmacist said that there had been several power cuts at the pharmacy. A power pack had been installed so that the fridge could operate for six hours while the main power supply was off.

## 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. |