General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ferry Pharmacy, 167 Ferry Road, Hullbridge, HOCKLEY, Essex, SS5 6JH

Pharmacy reference: 1092415

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

The pharmacy is located near to a surgery in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, blood pressure checks and uses private Patient Group Directions to supply Champix, nicotine replacement therapy medicines and erectile dysfunction medicine. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And supplies medicines in these packs to one care home. It provides substance misuse medications to a small number of people.

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 records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It generally protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood. Near misses were highlighted with the team member involved at the time of the incident; the dispenser said that the pharmacist usually pointed out the mistakes and they rectified their own mistakes. Near misses were recorded and reviewed regularly 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. A designated form was available for recording dispensing incidents. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. But an incident report form had not been completed. The pharmacist said that he had planned to do it and he would ensure that this was completed.

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 accuracy checking technician (ACT) knew which prescriptions she could check and the pharmacist initialled these to show that he had clinically checked them. She knew that she should not check prescriptions if she had been involved with dispensing the medicines.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistants (MCAs) said that the pharmacy would open if the pharmacist had not turned up. They would not sell any pharmacy-only medicines or hand out dispensed medicines until he had arrived. But they thought they could sell General Sales List medicines. The ACT thought that she could dispense prescriptions if there was no responsible pharmacist (RP). 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 medicine was made. And there were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. 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. The RP log was completed correctly and the pharmacist displayed the right RP notice after being prompted. The private prescription records were mostly completed correctly, but the prescriber's details and date of

dispensing was not usually recorded. 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. The pharmacist said that he would ensure that the private prescription record and emergency supply record were completed correctly in the future.

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 team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. 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 displayed in the shop area. The pharmacist said that there had not been any recent complaints, but some comments had been made about there only being one chair in the shop area for people to use. He said that he planned to have more chairs available in the future, but in the meantime additional seating from the consultation room could be used.

The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The team members could give examples of action they had taken in response to safeguarding concerns.

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 support their learning needs. And they can raise any concerns or make suggestions. 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 pharmacist (who was the superintendent), one ACT, one trained dispenser and two trained MCAs working during the inspection. Team members had completed accredited courses for their roles. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCAs appeared confident when speaking with people. One MCA, when asked, was aware of the restrictions on sales of pseudoephedrine containing products. 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.

The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. The pharmacist said that he planned to implement an online training system to allow team members to complete formalised training on a more regular basis. The team discussed near misses and dispensing incidents openly. The pharmacist and ACT were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. He said that he felt able to take professional decisions.

The pharmacist said that team members had regular informal appraisals and performance reviews, but these were not documented. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser said that team members often made suggestions about moving medicines around to allow better access to items which were dispensed more frequently. She also said that the pharmacist had asked for their opinions about a planned refit. The dispenser said that team meetings were held when needed to discuss any issues, but the pharmacy usually passed on information on to team members in a more informal way. Targets were not set for team members. The pharmacist said that he provided the services for the benefit of the people who used the pharmacy.

The pharmacist said that he had cut back on some of the services to ensure that the core services were well managed. He explained that there had been a few new members of staff recently employed and the pharmacy was concentrating on the core activities such as dispensing.

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, but some were potentially accessible to the side of the counter. The pharmacist said that he would ensure that these were not accessible in the future. 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.

Some people’s personal details were potentially visible on some bags of dispensed medicines. The pharmacist said that he would ensure that the information on the prescriptions was protected in the future. There was one chair in the shop area. This was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

There was limited floor space in the dispensary and there were some boxes that presented trip hazards for team members. The pharmacist said that he planned to extend the dispensary which would allow more space to store these items. And he would ensure that these were better placed in the future. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened, but it was not 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.

The consultation room computer screen was not kept locked when not in use. And there were folders containing people’s personal information in the room. There was CCTV in the consultation room, but there was no notice informing people of this and the pharmacist was not sure whether this could be switched off if someone needed to remove an item of clothing. The pharmacist said that he would display a notice informing people that they were being filmed.

Two nurses known to the pharmacy were allowed access to the dispensary during the inspection. The inspector reminded the pharmacist about ensuring access only to authorised people so that other people’s personal information was protected.

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. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy may be missing opportunities to speak with people taking higher-risk medicines when they collect these.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The pharmacy was in the process of carrying out an audit for lithium and lithium cards were handed out to people when needed. 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 higher-risk medicines were highlighted, but the pharmacist said that he did not routinely speak with these people when they collected their medicines. He said that he would review how the pharmacy managed people taking these medicines to ensure that they were taking them safely. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were highlighted to help reduce the chance of these medicines being supplied when the prescription is no longer valid. But, there were none found for these medicines during the inspection. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And he confirmed that he had spoken to any who were in the at-risk group. He explained that he had made a note on their medication record and recorded whether they needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every few months and this activity was recorded. Stock due to expire within the next six months were marked. There were a few expired medicines found with dispensing stock. The pharmacist said that he would ensure that a more reliable date-checking system was implemented in the 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. The pharmacist said that uncollected prescriptions were checked every three months. Items uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacist said that he carried out assessments for the people who requested to have 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; the ACT said that most people ordered these 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. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack, but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The ACT said that she would ensure these were attached in the future. 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. But 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. The pharmacist said that he would ensure that other people's personal information was protected when signatures were recorded in the future. 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. 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 to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that he had undertaken some training on how the system worked, but the dispenser had not yet done the training. The pharmacist confirmed that the pharmacy planned to start using the equipment fully in the near 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 was available. A separate liquid measure was marked for liquid controlled drug use only. An electronic tablet counter was available, but this was not clean inside. The pharmacist said that he would ensure that this was kept clean in the future. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said the blood pressure monitor had been in use for less than two years and it would be replaced in accordance with the manufacturer’s recommendations. 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.

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.