General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Derix Healthcare Pharmacy, 1065 London Road, LEIGH-ON-SEA, Essex, SS9 3JP

Pharmacy reference: 1092675

Type of pharmacy: Community

Date of inspection: 13/08/2024

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, an ear wax removal service and blood pressure checks. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it supplies medicines to a large number of people living in care homes. And it provides substance misuse medications to some number of people. This was a reinspection of the pharmacy, following a previous re-inspection in November 2023 when it was found not to be meeting all the Standards for registered pharmacies. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restriction imposed.

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 identifies and manages the risks associated with its services to help provide them safely. It has made improvement since the previous inspection, and it now records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. People can provide feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. And it largely protects people's personal information.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. One of the dispensers, when asked, knew which tasks should not be undertaken if the pharmacist had not turned up in the morning or if the pharmacist was absent from the premises.

Team members explained how near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with them at the time of the incident. And once the mistake was highlighted, they were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Team members said that the outcomes from the reviews were discussed openly with the team. One of the dispensers said that team members recorded their own near misses even if they discovered it themselves before the items were passed to the pharmacist to check. Gabapentin and pregabalin were already stored separately, but there had been some recent mistakes involving these medicines. Team members had been reminded to check their own dispensing before passing it to the pharmacist. A poster was displayed in the dispensary to remind team members to be aware of medicines which looked alike or sounded alike (LASA). And one of the dispensers said that team members had recently undertaken some training about LASA medicines. 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 had been delivered to the wrong person. The delivery driver was reminded to ask people to confirm their details before handing over a bagged item.

Workspace in the dispensary was limited but there were clear areas for dispensing and checking medicines. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The pharmacist said that people were referred to NHS 111 if they needed a prescription-only medicine in an emergency and they did not have a prescription. And records were made electronically if a supply was made. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not always recorded. The pharmacist said that he would ensure that this was recorded in future. The CD

running balances were checked at regular intervals. And 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. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. There were a few private prescriptions that did not have all the required information on them when the supply was made. The importance of ensuring that prescriptions were legally valid at the time of supply was discussed with the pharmacist.

People's personal information on bagged items waiting collection could not be read by people using the pharmacy. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Confidential waste was removed by a specialist waste contractor. Computers were password protected and people using the pharmacy could not see information on the computer screens.

The complaints procedure was available for team members to follow if needed and details about how people could provide feedback were displayed in the shop area. Team member said that there had not been any recent complaints.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. One of the dispensers, when asked, knew the potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they can raise any concerns or make suggestions and have regular meetings. The team members can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, five trained dispensers (one was enrolled on the NVQ level 3 pharmacy course, and one was the admin manager) and two trainee dispensers working during the inspection. One of the dispensers said that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. Team members worked communicated effectively during the inspection to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked relevant questions before selling an over-the-counter medicine to ensure it was suitable for the person it was intended for. One dispenser, when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

The admin manager was responsible for ensuring that team members completed regular training. She said that they were provided with online training and that they could complete it at work during quieter times or at home if they preferred. She said that they had to undertake assessments to show that they had understood the content of the modules. The pharmacist was of the continuing professional development requirement for revalidation. He said that he had recently undertaken training about the Pharmacy First service, head lice, and team building and motivation. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The admin manager said that the pharmacy held team meetings around once every three months and ad hoc when needed. She explained that important information was disseminated via the pharmacy group chat. Team members said that they had ongoing performance reviews and they felt comfortable discussing any issues with the pharmacist. The pharmacist felt able to make professional decisions. Targets were not set for team members. The pharmacist said that the 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. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access and 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. The pharmacy was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. And conversations at a normal level of volume 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

The pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers. It has made improvements since the previous inspection, and it now manages its medicines properly and stores them securely. And it highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines. 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 who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into 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. And the pharmacy could produce large-print labels for people that needed them.

The pharmacy had made improvements since the previous inspection and prescriptions for higher-risk medicines and Schedule 3 and 4 CDs were now highlighted. This meant that there was opportunity to speak with these people when they collected these medicines. The pharmacist said that he spoke with people about their medicines and checked that they were having the relevant blood tests carried out. Highlighting prescriptions for Schedule 3 and 4 CDs helped to minimise the chance of these being handed out when the prescription was no longer valid. And team members checked CDs and fridge items with people when handing them out. 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 (PPP). Team members said that they supplied these medicines in their original packaging. The pharmacist said that he would carry out a risk assessment for a person if they needed to have these medicines supplied not in their original packaging. And a this would be recorded on the patient's medication record. He explained that he ensured that the relevant warnings were on the packaging and the warning card was supplied. He said that he would refer people to their GP if they needed to be on the PPP and weren't on one.

The pharmacist recorded consultations for the Pharmacy First service electronically. He explained that he would routinely contact people if they had they had not attended the pharmacy after being referred by NHS 111 for an emergency supply of a medicine. The pharmacist and one of the dispensers were trained to provide the ear irrigation service. The pharmacy had made improvements with how it recorded consultations for the ear wax removal service. Paper consultation records were now completed for each treatment and a record was made on the person's medication record at the pharmacy. There were signed in-date patient group directions available for the relevant services offered.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. A dispenser explained the action the pharmacy took in response to any alerts or recalls. 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. 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 several months were marked. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging.

The pharmacy had made improvement with the way it stored its CDs, and these were now found to be stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Part-dispensed prescriptions were checked frequently and 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 regularly, and people were contacted if they had not collected their items after around two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

People had assessments to show that they needed their medicines in multi- compartment compliance packs to show that they needed them. 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. And prescriptions for 'when required' medicines were not routinely requested. The dispenser said that people requested these if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had checked each tray. And patient information leaflets were routinely supplied. Prescriptions for care homes were largely ordered and managed by the care homes. Prescriptions were checked when they were received to ensure that all items that had been requested had been prescribed. There were several team members who could assemble the packs, which meant that cover could be provided if needed.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible. 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 obtained in 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.

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

Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only.

The pharmacy had up-to-date reference sources, and these were also available online. The pharmacist said that the blood pressure monitor was replaced in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed. One of the dispensers explained that the equipment used for the ear wax removal service was cleaned regularly and records were kept. He said that disposable earpieces were used to maintain an appropriate level of hygiene.

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.