General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Southchurch Pharmacy, 535 Southchurch Road, Unit 6, SOUTHEND ON SEA, Essex, SS1 2AY

Pharmacy reference: 1104787

Type of pharmacy: Community

Date of inspection: 13/08/2024

Pharmacy context

The pharmacy is on a parade of shops on a busy road in a largely residential area. It provides NHS dispensing services, the New Medicine Service, emergency hormonal contraception, an ear wax removal service and the Pharmacy First service. It supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. This was a re-inspection of the pharmacy, following an inspection in December 2023 when it was found not to be meeting all of 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 adequately identifies and manages the risks associated with its services to help provide them safely. It has made improvements since the previous inspection and now protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). One of the team had signed to show that they had read, understood, and agreed to follow them. The pharmacist said that he would ensure all other team members read and signed ones relevant to their role. And they appeared to be following them during the inspection. The dispenser said that the pharmacy would not open if the pharmacist had not turned up in the morning. She said that she would attempt to contact the pharmacist and let people know that there was no pharmacist available. She knew what tasks she should not undertake if there was no responsible pharmacist (RP) signed in. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Team members said that the pharmacist highlighted with them when a dispensing mistake was identified before the medicine had reached a person (known as near misses). And once the mistake was highlighted, team members were responsible for identifying and rectifying them. The pharmacy had made improvements since the previous inspection and near misses were now routinely recorded. But they were not reviewed for any patterns, and this could limit learning. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing mistakes that had reached a person (known as dispensing errors) were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that he was not aware of any recent dispensing errors.

The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription.

The pharmacy had current professional indemnity insurance. And the right responsible pharmacist (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. The nature of the emergency was 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. The pharmacist said that he would ensure that these were recorded in future.

At a previous inspection, it was found that the pharmacy was not disposing of its confidential waste

appropriately. The pharmacy now ensured that its confidential waste was shredded. Computers were password protected and 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. People's personal information on bagged items waiting collection could not be read by people using the pharmacy.

The pharmacist said that there had not been any recent complaints. The dispenser said that she would refer any complaints to the pharmacist. The complaints procedure was available for team members to follow if needed.

Team members had completed training about protecting vulnerable people. They could describe potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. There had not been any recent safeguarding concerns at the pharmacy. But following an incident several months ago, the pharmacy now had the phone number of the local safeguarding team clearly displayed in the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Following the previous inspection, they now do the right training for their roles, and they are provided with some ongoing training. The team can take professional decisions to ensure people taking medicines are safe. And they can raise any concerns or make suggestions.

Inspector's evidence

There was one pharmacist (who was also the superintendent pharmacist), one trained dispenser, one trainee dispenser and one trainee MCA working during the inspection. The dispenser explained 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 communicated effectively during the inspection to ensure that tasks were prioritised. And the pharmacy was up to date with its dispensing.

The trainee MCA appeared confident when speaking with people. She said that she would refer to the pharmacist if a person requested to buy more than one box of pseudoephedrine-containing products. Or, if they regularly requested to purchase medicines which could be misused or may require additional care. She knew which questions to ask people to establish whether an over-the-counter medicine was suitable for the person it was intended for.

The dispenser said that she was not provided with ongoing training on a regular basis, but team members received some pharmacy-related updates. These were displayed in the pharmacy and team members signed to show that they had read and understood them. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had recently completed training about returning to prescribing, and safer prescribing and monitoring of higher-risk medicines. And he said that he had read the competency framework for all prescribers. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, and had done the associated training. And he felt able to make professional decisions.

Team members said that meetings were held informally if there were any issues that needed to be discussed or information needed to be disseminated. The dispenser said that performance reviews were ongoing and informal. Team members felt that they could discuss any issues with the pharmacist. Targets were not set for team members. Team members said that services were provided for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. The premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout which presented a professional image. And it was secured against unauthorised access. 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 on the day of the inspection 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 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. 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

Overall, 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 and largely 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.

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.

There were signed in-date patient group directions available for the relevant services offered. Consultations for the Pharmacy First service were recorded electronically. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription was no longer valid. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The dispenser said that team members checked CDs and fridge items with people when handing them out. 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 (PPP). The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy supplied these medicines in their original packaging.

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. 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 regularly, and this activity was recorded. The trainee dispenser said that team members used coloured stickers to highlight short-dated items. There were no short-dated items found during a random spot check. But there were a few medicines which were not kept in their original packaging. This had also been highlighted during a previous inspection. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The importance of keeping medicines in their original packaging was discussed with the pharmacist.

CDs were 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 temperature was showing as 11 degrees Celsius at the start of the inspection. This was reset and rechecked and it remained within the appropriate range for the remainder of the inspection. The fridge was suitable for storing medicines and was not overstocked.

Team members said that uncollected prescriptions were checked weekly. Items remaining 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. 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. Some dispensed medicines did not have the prescription readily available for team members to refer to when handing out. The pharmacist said that he would ensure that the dispensing tokens were available for team members to refer to in future.

People had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for some 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 dispenser said that people contacted the pharmacy 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 but the backing sheets were not attached to them which could increase the chance of them being misplaced. The dispenser said that she would attach these in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The dispenser wore gloves when handling medicines that were placed in these packs.

Deliveries were made by a delivery driver. 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 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 review this and ensure that other people's personal information was protected 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 was available and separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which 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.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor was replaced in line with the manufacturer’s guidance. And that the equipment used for the ear wax removal was cleaned before each use. Disposable tips were used for the otoscope which was also cleaned regularly. The weighing scales and the shredder were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.