General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Reydon Pharmacy, Solebay Health Centre, 1 Teal Close, Reydon, SOUTHWOLD, Suffolk, IP18 6GY

Pharmacy reference: 1124747

Type of pharmacy: Community

Date of inspection: 09/11/2022

Pharmacy context

This pharmacy is situated within a residential area, inside a dispensing doctor's practice. As well as dispensing NHS prescriptions the pharmacy provides a flu vaccination service. It also provides smoking cessation, c-card, a locally commissioned Emergency Hormonal contraceptive (EHC) service and chlamydia testing.

Overall inspection outcome

✔ **Standards 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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
		1.8	Good practice	The pharmacy has a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults.
2. Staff	Standards met	2.2	Good practice	Team members get time set aside for ongoing training and the pharmacy monitors their training.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team reaches out to the community to promote health and wellbeing and the pharmacy's services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy 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 protects people’s personal information well and it regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available. SOPs had been implemented by the superintendent pharmacist (SI) when she had taken over the role. Team members were allocated SOPs depending on their job roles. Team members had read the SOPs which were relevant to their roles. Team members had also commented on aspects of SOPs using post-it notes to provide feedback and suggestions and requested changes to be made where things were not described as how they were actually done. The team had been routinely ensuring infection control measures were in place and cleaned the pharmacy regularly through the day.

The pharmacy consistently recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded on a log or on the electronic system used to record people's medication records. Near misses were reviewed by the SI. A team discussion was held once the review had been completed. The team also informed the second pharmacist. Near misses were also discussed as they occurred. Following a discussion, the team had reinstated the paper log as it was easier to use. Previous reviews had found that near misses generally occurred when it was busier or when there had been staff shortages in the past and the dispenser had been interrupted. To prevent some near misses from reoccurring the team had moved some items away from each other in the drawers and team members were advised to take mental breaks when dispensing. The pharmacy team did not record names on the near miss log to ensure that there was a no blame culture. Dispensing errors would be investigated and followed up by the SI and a record would be made. Due to the number of people who were involved in the dispensing and checking processes, dispensing errors were rare. All errors were discussed with the individuals involved and with all team members.. As a result of a past error, the team ensured that starting dates were recorded on the front of each multi-compartment compliance pack to make sure it was supplied on the correct date. The prescription forms were also annotated with the start dates.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure. Complaints were dealt with by the SI, who followed up all complaints with a telephone call. Where people had specified specific instructions, these were flagged up on the electronic system, such as some people not liking to confirm their address loudly. The team were more aware of discussing people's medicines at the counter and informed people of the availability of the consultation room. A hearing loop had also been fitted following customer feedback.

Records about private prescriptions, emergency supplies, unlicensed medicines dispensed, controlled drug (CD) registers and RP records were well maintained. CDs that people had returned were recorded in a designated register as they were received. A random check of stock of a CD complied with the balance recorded in the register. CD balance checks were carried out regularly

Assembled prescriptions were stored in drawers in the dispensary and people's private information was not visible to others using the pharmacy. The pharmacy had an information governance policy available; team members had been briefed about this. Relevant team members who accessed NHS systems had smartcards. Pharmacists and the pharmacy technician had access to Summary Care Records (SCR); consent to access these was gained verbally. Confidential waste was separated and shredded. All team members had signed a confidentiality agreement.

Team members including the delivery driver had completed safeguarding training. The SI, second pharmacist and pharmacy technician had completed level 2 safeguarding training. All team members had downloaded the NHS safeguarding application. The team described that more concerns were picked up during deliveries. If the driver saw something which they were concerned about they would notify the RP who then spoke to the surgery, who then sent someone to see the person. The SI described that there had been a few instances where concerns had been raised in this way.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides. And the pharmacy supports them by giving them time at work to do ongoing training to help keep their knowledge and skills up to date. They do the right training for their roles. They work effectively together and are supportive of one another.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the SI, a pharmacy technician, a trained dispenser, and a trained medicines counter assistant (MCA). Team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The SI had recently spoken to the owner's family in relation to employing more staff. The pharmacy technician was leaving and the SI said there had been an increase in the number of items and over-the-counter sales and the SI was looking to provide more services. The SI had discussed recruiting another technician. The SI said that there were an adequate number of team members for the services provided at the time of the inspection. The team members were observed to be able to manage the workload and were up-to-date with their dispensing. Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment.

The SI had worked at the pharmacy since July the previous year. She described that the pharmacy was very community orientated and received positive feedback from people. People appreciated that team members took time out to talk to them.

Individual performance and development was monitored informally by the SI. Team members were provided with on-the-spot feedback. The team worked very closely together.. The SI was looking to formalise the appraisal process.

The team had created a training chart to ensure that everyone had completed the required training. The chart recorded what training each team member needed to complete and showed the date of when the training needed to be done by. Team members were provided with allocated time to complete their training. The SI asked team members if they were interested in completing any training. Team members who covered the counter also completed training modules. Team members were informed of changes to legislation including changes in the legal categories of medicines via email. The SI briefed the team and made sure everyone was aware. The SI and pharmacy technician had recently completed a cancer research webinar in the evening and the SI had also completed additional training on the eLearning for healthcare site.

One of the team members who was not present during the inspection was completing the MCA training course. The trained dispenser had been offered to complete the accuracy checking course and was due to start. The SI was the tutor for all trainees, and team members completing formal training were provided with additional training time to complete this.

As the team was small and worked closely together things were discussed as they came up. Decisions were generally made jointly by the SI and pharmacy technician and dispenser. The second pharmacist worked one day a week and was kept informed about changes. Team members felt able to provide the

SI with feedback and suggestions. There were no formal numerical targets set for the team but team members set each other informal targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy premises were modern, large, bright, clean, and organised. The dispensary was spacious, there was ample workspace which was clutter-free. Workbenches were allocated for certain tasks. A sink was available for preparing medicines. There was a separate area at the back and to one side used as a staff area and office during the day by the pharmacy and in the evenings by out-of-hours district nurses. There was separate key coded access into the space. There was no confidential information kept in the room; the medicines fridge was locked as was the door leading into the dispensary and other areas of the pharmacy. Cleaning was carried out by team members in accordance with a rota. The pharmacy was clean and well maintained.

A consultation room was available. The room allowed a conversation at a normal level of volume to take place inside without being overheard. The space was large and of a suitable size for services. There were two entrances from the retail area. Confidential information was inaccessible. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services and takes steps to make sure people can use them. It provides its services safely. It gets its medicines from reputable sources, and it manages them appropriately so that they are safe for people to use. And it takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can easily access the pharmacy's services.

Inspector's evidence

The pharmacy was easily accessible. There was a ramped front entry into the surgery and all doors leading in from the car park were automatic. The floor space in the pharmacy was clear and open with easy access to the medicines counter. There was a lowered front counter within the retail area which allowed easy access for people with mobility issues. Car parking was available outside and there were designated disabled parking bays. A hearing loop was available at the counter. Team members were aware of the need to signpost people to other services. A signposting folder with details about local services was available and team members also used NHS websites. As well as signposting people who visited the pharmacy, those who telephoned were also directed to appropriate services. Team members recorded any signposting advice in people's electronic records.

The team felt that the New Medicine Service and delivery service had the most impact on the local population. They described the client base as mostly elderly, and felt people using the pharmacy felt more able to speak to the pharmacist about any questions as most did not want to bother the doctors. The SI made it clear during conversations that they could call the pharmacy to speak to someone when they needed. Due to the location of the pharmacy the SI or team members were able to go to the surgery and make referrals relatively quickly. Team members described how some people still had a misconception that surgeries were not seeing people. The team had realised that there were quite sick people who hadn't seen a doctor. The SI had referred people to their GP which had resulted in three separate diagnoses of embolism, lung cancer and bowel cancer. The team members always asked people to call if they had a concern about anything health related. And in the past they had had a number of people call up because of this.

The pharmacy had an established workflow. Colour-coded baskets were used as part of the dispensing process to separate prescriptions. Cards were attached to some of the prescriptions by the team. Cards were used when a person needed to be counselled by a pharmacist or if there was a fridge line or CD dispensed. It was very rare that the RP had to self-check as she did not work on her own. Dispensed and checked-by boxes on labels were initialled by members of the team to create an audit trail for the dispensing and checking processes.

The SI and team members were aware of the current guidance for dispensing sodium valproate. The team would flag prescriptions for sodium valproate to the pharmacist. A drawer in the dispensary was used to store all the sodium valproate resources. The team would make sure any dispensed sodium valproate had the correct labelling and tried not to cover any important patient information with the dispensing label. The pharmacy did not currently have any people in the at-risk group. When sodium valproate was supplied to care homes, extra alert cards were added. A pharmacist card was attached with prescriptions for medicines that required additional monitoring. People were not able to order

repeat prescriptions for warfarin without supplying the surgery with their latest INR readings. The pharmacy team did not regularly check INR when supplying warfarin. The SI and pharmacy technician provided an assurance that they would start checking and making a record. The MCA checked people's electronic records before selling medicines to check for interactions. This was observed during the inspection and the MCA referred to the SI when dealing with a request from a person who was taking anticoagulants.

Flu vaccinations were generally only provided on an appointment basis. However, the SI would do a walk-in vaccination for someone if there was a need.

Some people's medicines were supplied in multi-compartment compliance packs. The pharmacy ordered prescriptions on behalf of people for this service. To help organise and manage the service people were allocated to different weeks and each person on the service had a separate record. Records were split into two folders depending on whether packs were supplied weekly or monthly. Records were annotated for when they were due and an up-to-date repeat slip and updated master sheet was kept. The pharmacy only ordered medicines which were supplied in the packs; people were required to order other medicines themselves. Packs were only prepared when prescriptions were received and were only prepared at least two weeks before the start date. Any changes and missing items were recorded and queried with the surgery. If people were admitted into hospital information was either received via Pharm Outcomes or from the surgery. Assembled packs were labelled with product descriptions and mandatory warnings. Patient information leaflets were provided monthly. There was an audit trail to show who had prepared and checked the packs. However, the backing sheets were placed loosely in the pack. The team acknowledged that there was a risk that these could be lost and provided an assurance that these would be securely attached.

The pharmacy had a delivery driver and delivery records were generated by the computer and retained. In the event that a person was not home the driver tried a second time later in the delivery round and if they were still not available the medicines bag was returned to the pharmacy. Signatures were no longer obtained in most cases when medicines were delivered and this was to help infection control.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for storing medicines. CDs were held securely.

Expiry date checks were carried out at least every three months or more frequently. Short-dated stock was marked with stickers. A date-checking matrix was in place. There were no date-expired medicines found in the drawers checked. Out-of-date and other waste medicines were separated from stock and then collected by licensed waste collectors.

Drug recalls were received via email. The team printed these and checked against stock. If the affected batches were found these were quarantined and the appropriate action was taken. Any action taken was recorded on the sheet and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. Equipment was clean and ready for use. Three medical grade fridges of adequate size were available. The pharmacy was not providing any services at the time of the inspection which required the use of any monitors. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

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.