General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Audley Mills Pharmacy, 55-57 Eastwood Road, Rayleigh, Essex, SS6 7JE

Pharmacy reference: 9011130

Type of pharmacy: Community

Date of inspection: 27/08/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre and it is surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 85% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, flu vaccinations, chlamydia testing and treatment, emergency hormonal contraception and smoking cessation. It supplies medications in multi-compartment compliance packs to several people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a few 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

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

Inspector's evidence

The pharmacy adopted some of measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident 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. The pharmacist said that near misses were recorded and reviewed regularly for any patterns. But the near miss logs were not available at the pharmacy on the day of the inspection. The pharmacist said that he had taken them home to review. The pharmacy technician said that there had been some near misses recently. But the pharmacist had been on leave for a couple of weeks and the near misses had not been recorded during this time. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. And these were reported on the National Reporting and Learning System. Learnings from reported incidents were shared between different organisations. The pharmacist said that dispensing incidents were discussed during the monthly pharmacy patient safety meeting. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person had returned it to the pharmacy and had not taken any of the incorrect medicine. The correct medicine was supplied and the pharmacist said that the person was satisfied with how the error had been dealt with. He said that he would write to the person and offer an apology on behalf of the pharmacy.

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.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy technician said that the pharmacy would remain closed if the pharmacist had not turned up. She explained that the pharmacists would contact her if they were running late. She said that she would let people know the situation and signpost them to another local pharmacy if needed. The trainee medicines counter assistant (MCA) knew that he should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

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. The pharmacy had signed in-date patient group directions for the services offered and the private prescription record was complete. 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. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked regularly. Any liquid 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) log was completed correctly and the correct RP notice was clearly displayed.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the March 2019 survey were displayed in the shop area and were available on the NHS website. Results showed that over 98% of people who responded had rated the pharmacy as excellent or very good overall. And 4% of people were not satisfied with 'having somewhere available where you could speak without being overheard'. The consultation room was clearly advertised and the pharmacist routinely offered the use of this. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed training provided by the pharmacy. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. 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 ongoing and structured training to support their learning needs and maintain their knowledge and skills. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist, one pharmacy technician, two trained dispensers, one trainee dispenser and one trainee MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. He was aware of the restrictions on sales of pseudoephedrine containing products. And he confirmed that he 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.

Team members had either completed or were enrolled on an accredited course for their role. The pharmacist and the pharmacy technician were aware of the Continuing Professional Development requirement for the professional revalidation process. The pharmacist said that team members were provided with ongoing training on a regular basis but the training records had not been kept up to date. He said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members had yearly appraisals and performance reviews with the pharmacist. The pharmacy team had a monthly patient safety review to ensure that all team members were aware of any errors and improvements. Team members said that they felt comfortable about discussing any issues with the pharmacist. A communications book was used to pass on important information and help with the running of the pharmacy when different pharmacists were working.

Targets were set for Medicines Use Reviews. The pharmacist said that these services were provided for the benefit of the people who used the pharmacy and not to meet the targets. He said that the targets would not affect his professional judgement.

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. 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; the room temperature was suitable for storing medicines.

The pharmacy underwent an extension and refit around six months ago. It had been fitted out to a high standard and this presented a professional image. It was bright, clean and tidy throughout. There was a door to the rear of the shop area which led to a surgery. This door was kept secured when the surgery was closed.

There were two chairs and a padded bench in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was accessible from the shop area and the dispensary. 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.

The toilet facilities and kitchen area 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 manages its services well and provides them safely. 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 doesn't always keep prescriptions at the pharmacy until medicines are collected. And this could increase the chance of these being supplied when the prescription is no longer valid.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power assisted door. Services and opening times were clearly advertised and a variety of health information leaflets were available. A hatch was used from 10pm to midnight.

The pharmacist said that if the pharmacy received a prescription for a higher-risk medicine such as methotrexate and warfarin, the pharmacy asked the person for their recent blood test results before it was dispensed. And a record of blood test results was kept on the person's medication record. This helped the pharmacy to check that the person was having the relevant tests done at appropriate intervals. And meant that there was opportunity to speak with the people about their medicines. Prescriptions for Schedule 3 and 4 CDs were not usually highlighted. The pharmacist said that he would ensure that these were highlighted to minimise the chance of these being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacy technician said CDs and fridge items were checked 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. Patient information leaflets or warning cards were not available. But some packs did have the warning card attached. The pharmacist said that he would order replacements from the manufacturer.

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 six months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked twice a day. '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 not kept at the pharmacy until the remainder was supplied. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of items being handed out when the prescription was no longer valid. Uncollected prescriptions were checked monthly. Items uncollected after three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

Prescriptions for people receiving their medicines in multi-compartment compliance 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 when they needed them. 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. Patient information leaflets were routinely supplied. Packs were suitably labelled but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were not put on the packs to help people and their carers identify the medicines. The pharmacist said that medication descriptions were available on the leaflets. He said that he would ensure that the backing sheets were attached to the trays in future.

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 at the time of destruction.

Deliveries were made by delivery drivers. The pharmacy obtained people’s signatures on hand-held electronic devices for deliveries where possible and these were recorded in a way so that another person’s information was protected. 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. The pharmacist said that drug alerts and recalls were received from the NHS and the MHRA and actioned. But the pharmacy did not keep a record of the action taken, which could make it harder for the pharmacy to show what it had done in response. He said that he would ensure that there was an audit trail kept in future.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The pharmacist said that he and the team had undertaken some training on how the system worked. He said that there were written instructions for the process. And planned to implement the use of the equipment soon.

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 but not for volumes less than ten millilitres. Separate liquid measures were marked for methadone use only. 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 that the blood pressure monitor had been in use for around four months. He confirmed that it would be calibrated yearly. 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 using a data logger which constantly monitored the temperatures. Records indicated that the temperatures were consistently within the recommended range. The pharmacy could check how long that the fridge temperature had been outside the recommended range if this happened. The fridges were suitable for storing medicines and were 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.