General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Care Pharmacy, Unit 1, 37 to 39 Kingsland Road, West Mersea, Colchester, Essex, CO5 8RA

Pharmacy reference: 9011394

Type of pharmacy: Community

Date of inspection: 19/11/2024

Pharmacy context

The pharmacy is in a largely residential area on Mersea island. It provides NHS dispensing services and the New Medicine Service. And it supplies medicines in multi-compartment compliance packs to some people who live in their own homes and need this support.

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 protects people's personal information well. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. And the pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. But the trainee dispenser said that she had not read them since 2017 when she had previously worked at the pharmacy. The trainee dispenser knew that she should not sell medicines or hand out dispensed items if the pharmacist was not in the pharmacy. And she would not undertake any dispensing tasks if there was no responsible pharmacist (RP) signed in.

Items in similar packaging or with similar names were separated on shelves where possible to help minimise the chance of the wrong medicine being selected. The trainee dispenser explained that the pharmacist highlighted near misses (dispensing mistakes identified before the medicine had reached a person) with her. And she was responsible for identifying and rectifying the mistakes. The pharmacy had not been recorded any near misses for several months and team members confirmed that there had been some. The pharmacist said that she would ensure that near misses were recorded in future and that the record would be reviewed for patterns. Dispensing errors (dispensing mistakes that had reached a person) were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The person had not taken any of the medicine and the pharmacist delivered the correct medicine to them on the day that the error was noticed. The pharmacist said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed.

The pharmacy had current professional indemnity insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. And the private prescription records were completed correctly. Controlled drug (CD) registers examined were filled in correctly. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The pharmacist confirmed that a full CD running balance check had not been carried out for several months. The relatively long time between checks for less-frequently used CDs could make it harder for the pharmacy to identify any errors or loss of medicines promptly. The correct RP notice was clearly displayed, and the RP record was largely completed correctly. But the pharmacist had not made entries for a couple of weeks as there were no pages left. She completed an entry for the day of the inspection and confirmed that she had been the RP on the days that the record had not been completed. She explained that said that she had ordered a new book and she would ensure that the RP record was completed correctly in future.

Smartcards used to access the NHS spine were stored securely and team members used their own

smartcards during the inspection. Confidential waste was shredded, computers were password protected and people using the pharmacy could not see information on the computer screens. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people and team members had completed training about protecting vulnerable people. When questioned, the trainee dispenser described 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. And they can complete training at work to help keep their knowledge and skills up to date.

Inspector's evidence

There was one trainee dispenser working in the pharmacy at the start of the inspection. And she had been working at the pharmacy for around one year. She said that the pharmacist had to leave the pharmacy to make an urgent delivery to a person. The trainee dispenser was informing people that the pharmacist was not available and provided them with an estimated time that they would be able to collect their medicines. She offered for people to have their medicines delivered. The pharmacist and trainee dispenser worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was seen to be up to date with its dispensing.

The trainee dispenser appeared confident when speaking with people. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. And she was aware of the restrictions on sales of medicines containing pseudoephedrine. She asked people relevant questions to establish whether the medicines were suitable for the person they were intended for.

The trainee dispenser explained that she preferred to do her training modules at home but could do them in the pharmacy during quieter times. The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she had recently completed training for the NHS Pharmacy First service.

There were no formalised meetings, but the pharmacist and trainee dispenser explained that they discussed any issues as they arose. The trainee dispenser said that she had ongoing informal performance reviews and she felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist felt able to make professional decisions and performance targets were not set for team members.

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 largely tidy throughout which presented a professional image. It 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 room temperature was suitable for storing medicines on the day of the inspection, but air conditioning was not available. The pharmacist said that the room temperature was suitable during the warmer months and the pharmacy used fans and covered the front window with a blind when needed.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. 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. The pharmacy gets its medicines from licensed wholesalers and largely stores them properly. It responds appropriately to drug alerts and product recalls. And people with a range of needs can access the pharmacy's services.

Inspector's evidence

Services and opening times were clearly advertised, and a variety of health information leaflets was available. There was a small step down into the pharmacy. Team members had a clear view of the main entrance from the dispensary and could help people into the premises where needed.

Workspace in the dispensary was free from clutter. And 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 trainee dispenser did not initial dispensing labels when she dispensed an item. This might mean that the pharmacy cannot easily identify who had dispensed an item and limit its ability to learn from mistakes. However, the pharmacist initialled when she checked each item to show that she had completed this task. The pharmacist said that she would ensure that the labels were routinely initialled when the items were dispensed in future.

Prescriptions for higher-risk medicines were not highlighted. The pharmacist said that she handed these out and routinely spoke with people about their medicines. And she checked monitoring record books for people taking higher-risk medicines such warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that she would consider recording these in future. Prescriptions for Schedule 3 and 4 CDs were not highlighted. And the dispenser initially said that these prescriptions for CDs were valid for six months and all other prescriptions valid for one year. When shown a prescription for a Schedule 3 and 4 CD she said that this prescription was valid for three months, but she quickly corrected herself. Not highlighting prescriptions for Schedule 2 and 3 CDs could increase the chance of these medicines being supplied when the prescription was no longer valid. The pharmacist explained that all prescriptions were checked with her before being handed out and she routinely checked the validity of the prescriptions. The pharmacy did not have any people taking valproate medicines. The pharmacist explained that she would refer people to their GP if they needed to be on the PPP and weren't on one. And the pharmacy would dispense these medicines in their original packaging.

Stock was stored in an organised manner in the dispensary and team members said that expiry dates were checked regularly. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. 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 pharmacist disposed of these medicines during the inspection and said that she would ensure that medicines were kept in their original packaging in future. 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. But the pharmacy did not keep a record of any action taken, which could make it harder to demonstrate

appropriate action had been taken in the event of a concern or query. The pharmacist said she would keep a record in future.

CDs were stored in accordance with legal requirements and 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 checked daily and consistently within the recommended range. The current temperature showing on the thermometer was 5.6 degrees Celsius. But the maximum was 14.7 degrees Celsius and the minimum -0.3 degrees Celsius. The pharmacist confirmed that she had already ordered a replacement thermometer. The fridge was a domestic type and was not overstocked.

There were no part-dispensed prescriptions at the pharmacy on the day of the inspection. The pharmacist explained that 'owings' notes were be provided if a prescription could not be dispensed in full, and people were kept informed about supply issues. And prescriptions for alternate medicines were requested from prescribers where needed. The pharmacist said that uncollected prescriptions were checked regularly, and people were contacted if they had not collected their items after around three months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacy supplied medicines in muti-compartment compliance packs to some people. A suitability assessment was completed by the pharmacist or the person's GP to identify which medicines were needed to be dispensed into the packs. The pharmacy did not routinely order prescriptions on behalf of people who received their medicines in these packs. But it ordered prescriptions for a few people if they couldn't do this themselves. Prescriptions were ordered in advance so that any issues could be addressed before people needed their medicines. And the pharmacist explained that she spoke with each person before requesting a prescription for their medicines. 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 pack. Medication descriptions were not detailed on the packs to help people and their carers identify the medicines and patient information leaflets were only supplied around every three months. This meant people might not have up-to-date information about their medicines. The importance of providing patient information leaflets was discussed with the pharmacist and she confirmed that these would be provided in future.

Deliveries were made by the pharmacist on an ad hoc basis for people who needed this service. The pharmacy did not currently obtain people's signatures. The pharmacist contacted people before attempting the delivery to ensure that they would be in.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely 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 25 millilitres. The pharmacist said that she would order a suitable measure. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. Up-to-date reference sources were available online. The phone in the dispensary was portable so it could be taken to a more private area where needed. And the shredder was in good working order.

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.