General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rochford Pharmacy, 15 West Street, Rochford, Essex, SS4 1BE

Pharmacy reference: 9011471

Type of pharmacy: Community

Date of inspection: 18/11/2021

Pharmacy context

The pharmacy is located opposite a small shopping precinct in a largely residential area, near Rochford train station. The pharmacy provides a range of services to a mixed population and it receives around 98% of its prescriptions electronically. Some of the services offered include, the New Medicine Service, a stop smoking service and blood pressure checks. And it also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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. Team members understand their role in protecting vulnerable people. And they record and review their mistakes so that they can learn and make the services safer. The pharmacy largely protects people's personal information. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy had carried out workplace risk assessments in relation to Covid-19. And it adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The outcomes from the reviews were discussed openly during the regular team meetings. The pharmacist said that using the dispensing robot had helped to minimise the number of mistakes during the dispensing processes. Dispensing errors, where a dispensing mistake had reached a person, were recorded on the pharmacy's online reporting system and a root cause analysis was undertaken. A recent error had occurred where a medicine had been placed in the wrong persons bag. The medicines were returned to the pharmacy.

There was ample workspace in the dispensary, and it was free from clutter. An organised workflow helped team members prioritise tasks and manage the workload. Prescriptions for 'walk-ins' were processed on the computer at the medicines counter when a person presented to collect their medicines. The robot selected the medicine and dispensed it into a tray and the dispensing token and labels were passed to the pharmacist. The pharmacist checked the medicine against the dispensing token and the labels, and then attached the labels to the medicines. He then took a short mental break before carrying out an accuracy check and clinical check. The medicines were bagged and passed to a team member to hand to the person. Baskets were used to minimise the risk of medicines being transferred to a different prescription. 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 dispenser said that the team could not access the pharmacy if the pharmacist had not turned up. All team members had the superintendent pharmacist's (SI) phone number, and they would contact him if they could not get into the pharmacy. Team members knew what tasks could and couldn't be carried out if the pharmacist was absent from the premises.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. 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 CD item checked at random was the same as the physical amount of stock available. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist corrected this during the inspection and said that he would remind all team members about ensuring the correct information was added to the electronic register. The nature of the emergency was not always 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. The pharmacist said that he would ensure that this information was recorded in future.

Confidential waste was shredded, computers were password protected and the 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. Team members had completed training about protecting information. Most bagged items waiting collection were kept in drawers behind the counter, but there were some on shelves to the side of the counter. While people's information could not be seen from the shop area, some bags could potentially be accessed by people using the pharmacy. The pharmacist said that he would ensure that these were safeguarded from unauthorised access.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out for 2020 to 2021. The dispenser said that she would refer any complaints to the SI. And she said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training, including equality and diversity and human rights, awareness of mental health, dementia and learning disability. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And she confirmed 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 training to support their learning needs and maintain their knowledge and skills. And they are able to complete this training at work. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, one trained dispenser, two trainee dispensers and two trainee medicines counter assistants (MCAs) working during the inspection. Some team members had completed an accredited course for their role and the rest were undertaking training. 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. She was aware of the restrictions on sales of pseudoephedrine-containing products. And she 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. The trainee dispenser referred to the pharmacist during the inspection to confirm a person's previous medication history with them.

Team members undertook regular ongoing training, and this could be completed while at work during quieter periods. Recent training included manual handling and fire safety. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to take professional decisions. The pharmacy maintained an intervention and signposting log. And the pharmacist had recently recorded when he had recommended an alternate medicine for one which had been discontinued. The pharmacy had daily meetings with the local surgery to discuss any prescription related or stock availability issues. The team discussed any dispensing mistakes openly during team meetings. And the pharmacy kept a record of the points discussed during the meetings. Team members were able to discuss any issues with the pharmacist or make any suggestions for change. The layout of the dispensary had recently changed due to staff feedback. And there had been an improved workflow because of the changes. Team members had yearly appraisals and performance reviews, but most information was passed on informally during the day.

The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

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 had recently relocated to a larger premises near the previous site. It was secured from unauthorised access. And it was bright, clean and tidy throughout and this presented a professional image. 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 was suitable for storing medicines.

There were clear screens at the medicines counter to help minimise the spread of infection. There were markings on the floor to help people maintain a suitable distance from each other while in the shop area. There were two chairs 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 located in the shop area. 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 and the staff kitchen areas 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 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.

Inspector's evidence

There was wide, step-free access to the pharmacy through two automatically opening doors (one at the front of the pharmacy and one at the rear). Team members had a clear view of the main entrances from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacist said that the pharmacy was in the process of applying to be a Healthy Living Pharmacy. Team members had undertaken the necessary training and the service lead would be an advanced nurse practitioner.

Prescriptions for higher-risk medicines were not routinely highlighted. The pharmacist said that he highlighted prescriptions if he wanted to speak with the person when they collected their medicine. And he explained that a person would not be issued a prescription if they did not have an in-date blood test. Prescriptions for these types of medicines were usually managed by prescribers at the hospitals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The trainee MCA was not aware that prescriptions for these types of medicines were only valid for 28 days. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that he would ensure that these prescriptions were highlighted in the future. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that CDs and fridge items were checked with people when handed 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. The pharmacy did not have the relevant patient information leaflets or additional warning cards available. The pharmacist said that he would order these from the manufacturer.

Stock was stored in an organised manner in the dispensary and in the pharmacy's dispensing robot. Medicines were given a year expiry when placed in the robot. If the medicines were not used in this time, then they would be ejected from the robot and a team member would input the expiry date manually before returning them to the robot. Expiry dates for medicines not kept in the robot were checked every three months and this activity was recorded. Stock due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked regularly. '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 and collected. The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message when their medicine was dispensed and then a reminder if they had not collected their items after around one month. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these 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 they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the backing sheets were not attached to the packs. This could increase the chance of them being misplaced. The dispenser said that she would ensure that these were attached in future. Medication descriptions were not put on the packs and this could make it harder for people and their carers identify the medicines. The dispenser said that this information was not recorded due to the time it took. Patient information leaflets were routinely supplied.

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 and destroyed with a witness, and two signatures were recorded.

Deliveries were made by some of the dispensary staff. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The pharmacist explained that the team member would check the person's details before handing over the items. He said that the pharmacy was in the process of implementing a delivery app, which would make the process easier. 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. 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 on the pharmacy's electronic record and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

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. Separate liquid measures were used to measure marked for methadone use only, but these were plastic. The pharmacist ordered suitable measures during the inspection. Triangle tablet counters were available and clean. 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.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than two years and had a date to show when it needed to be replaced. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. The dispensary area was large enough for staff to maintain a suitable distance from each other. And the pharmacy had personal protective equipment available, including masks, gloves and hand sanitiser.

Fridge temperatures were checked daily. The fridge alarm would sound if the temperature was outside the recommended range. The fridge kept a continuous log of the temperature and this could be checked to find out how long the temperature had been out of range. The pharmacist could use this information when contacting the medicines manufacturers so that a decision could be made as to whether they were safe to use. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was 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.