General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ashworths Dispensing Chemists, 229 Beaver Road, ASHFORD, Kent, TN23 7SJ

Pharmacy reference: 1032566

Type of pharmacy: Community

Date of inspection: 17/12/2019

Pharmacy context

The pharmacy is located in a largely residential area near to a surgery. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and influenza vaccinations. It also provides medicines as part of the Community Pharmacist Consultation Service. And it receives around 90% of its prescriptions electronically. The people who use the pharmacy are mainly older people. 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.

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 who use the pharmacy can provide feedback about its services. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people. But the pharmacy 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 adopted adequate measures for identifying and managing risks associated with its activities. There were documented, up-to-date standard operating procedures (SOPs) available. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were not recorded or reviewed regularly for any patterns. The dispenser said that the new owner had plans to implement a system for recording and reviewing near misses. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist explained how he would record any dispensing incidents on a designated form and he said that a root cause analysis would be undertaken. He said that he was not aware of any recent incidents.

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 dispenser explained that the pharmacy would not open if the pharmacist had not turned up. The trainee medicines counter assistant (MCA) said that she would not sell any pharmacy-only medicines or hand out any 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. There were signed in-date Patient Group Directions available for the relevant services offered and 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 kept. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. 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. The pharmacist said that he would ensure that the private prescription record and emergency supply record were completed correctly in the future.

Confidential waste was removed by a specialist waste contractor, 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. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy was in the process of carrying out a patient satisfaction survey; results from previous surveys were not available on the NHS website. The complaints procedure was available for team members to follow if needed. The dispenser said that there had not been any recent complaints at the pharmacy.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had been provided with some safeguarding training at the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. 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 do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. 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, two trained dispensers and one trainee MCA working at the pharmacy during the inspection. The dispenser said that a pre-registration trainee was assigned to the pharmacy, but they were not working on the day of the inspection. Most 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 explained that she would refer to the pharmacist if a person requested to purchase any pharmacy-only medicine. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He said that he felt able to take professional decisions and he explained that a second pharmacist was employed to carry out the influenza vaccination service. An appointment system was used and this meant that the other services were not disrupted. The dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The dispenser explained that the pharmacy’s head office organised regular meetings and frequently passed on important information. She said that the information was usually discussed informally and targets were not set for team members.

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 was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. The pharmacy had recently undergone a refit an this had increased the size of the dispensary. 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.

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 and well-screened. Low-level conversations 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 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 highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance 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 needle exchange bin was kept in the shop area and people could deposit their full sharps containers into the bin but they could not access the contents. This meant that team members did not have to handle the returned sharps containers.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and 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. 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 prescriptions for Schedule 3 and 4 CDs were highlighted and the trainee MCA knew that these were only valid for 28 days. There were none found waiting collection on the day of the inspection. 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. He said that the warning cards were routinely supplied with the medicines and these were available at the pharmacy.

Stock was stored in an organised manner in the dispensary. The dispenser said that there had not been a full check of the expiry dates of all medicines carried out since around May 2019. She said that short dated items were not marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked daily. '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 always kept at the pharmacy until the remainder was dispensed. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of errors. The dispenser said that the pharmacy would keep a copy of the prescriptions in the future. Uncollected prescriptions were checked infrequently. There were some items waiting collection which had been dispensed over six months ago and the prescriptions had not been kept with these. The trainee MCA said that she would always check with the pharmacist before handing out bagged items if the prescription was not attached. But the pharmacy may not know when the items had been prescribed and this could increase the risk of these being handed out when the prescription was no longer valid.

The pharmacist said that assessments were carried out by people's GP to show that they needed to have 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 the pharmacy contacted people to ask 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 generally suitably labelled, but there was no audit trail to show who had dispensed and checked each tray. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. Medication descriptions were put on the packs to help people and their carers identify the medicines. But patient information leaflets were not routinely supplied. And cautionary and advisory warning labels were not recorded on the backing sheets. This could make it more difficult for people to have up-to-date information about their medicines or to know how to take their medicines safely.

CDs were largely 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; two signatures were recorded.

Deliveries were made by one of the dispensers. The pharmacy obtained people's signatures 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. Drug alerts and recalls were received from the NHS and the MHRA. 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. The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that the pharmacy was likely to start using the equipment in the new year.

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 for measuring methadone. 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 in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. 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.