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: 08/01/2024

Pharmacy context

The pharmacy is in a largely residential area near Ashford town centre. It provides NHS dispensing services and it also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines to a few care homes and some of these medicines are in multi-compartment compliance packs. And it provides substance misuse medications to a small number of people. The pharmacy receives most of its prescriptions electronically.

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 largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. People using the pharmacy can provide feedback about its services. The pharmacy largely protects people's personal information. And some team members understand their role in protecting vulnerable people, but some of them may benefit from some additional training about safeguarding.

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. During the inspection, the pharmacist highlighted a near miss (a dispensing mistake which had been identified before the medicine had been handed out) to the team member involved. The team member rectified their own mistake, and a record of the near miss was made by the pharmacist. The pharmacist said that she would encourage team members to record their own mistakes in future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake 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 pharmacist said that she had reported the error to the pharmacy's head office.

Workspace in the dispensary was free from clutter and there were separate areas for dispensing and checking medicines. 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. Team members initialled 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. Team members knew which tasks they should not undertake if the pharmacist had not turned up in the morning. If the team members were not able to contact the pharmacist, they would inform the pharmacy's head office. And they knew that they 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 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. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running balances were checked at regular intervals. And 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 largely completed correctly, but the prescribers' details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. A private prescription dated in October 2022 had been dispensed in October 2023. The pharmacist said that the prescriber had attended the pharmacy before writing the prescription, so she was sure it was just dated incorrectly. And she would contact the prescriber to ask them to amend the prescription date. She said that she would remind team members to check the date

on prescriptions during the dispensing and checking processes. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there was an occasion recently where the RP had not completed the record at the end of their shift and another pharmacist was RP the following day. This was discussed with the pharmacist during the inspection.

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. But team members were using a smartcard belonging to a team member who was not working at the pharmacy on the day of the inspection to access electronic prescriptions. The pharmacist replaced it with her own card during the inspection and said that she would remind team members to only use their own smartcards in future. People's personal information on some bagged items waiting collection could potentially be read by people in the shop area. The pharmacist turned the bags so that the information was hidden.

The pharmacist said that there had not been any recent complaints. And she explained that if she was not able to resolve a complaint, she would refer it to the pharmacy's head office. The pharmacy's 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. Some other team members said that they had undertaken some safeguarding training, but one team member had not done any. And that team member was not sure about who might be classed as vulnerable. The delivery driver did not recall having done any safeguarding training, but he knew what to do if he had any concerns about a vulnerable person. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. And 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 team members to provide its services safely and they do the right training for their roles. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. And they can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist and three trainee dispensers working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The pharmacy was up to date with its dispensing. The trainee dispenser working on the medicines counter appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. And said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And she asked people questions to establish whether an over-the-counter medicine was suitable for the person.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. And she felt able to make professional decisions. She explained about a time where she had queried a person's dose of their medicine with the prescriber as it was more than the recommended dose. She said that she read pharmacy-related articles online and passed on relevant information to other team members. Such as supplying valproate medicines only as full packs.

The pharmacist said there were informal morning huddles which allowed team members to discuss any issues and to allocate tasks for the day. Team members mentioned that they had been working at the pharmacy for less than a year, but they thought they would have an appraisal carried out soon. They felt comfortable about discussing any issues with the pharmacist or making any suggestions. And the pharmacist said that she would contact the pharmacy's head office if she had any concerns. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, and people can have a conversation with a team member in a private area. And the premises largely provide a safe, secure environment for the pharmacy's services.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout. 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.

The pharmacy was largely secured from unauthorised access. At the start of the inspection, the door to the vaccination area was open but the pharmacist locked it when prompted. She said that the pharmacy’s delivery driver used this entrance. She said that she would ensure that this was kept locked in future when not in use. Bagged items were kept in boxes to the side of the medicines counter. Some of the bags were potentially accessible to people using the pharmacy. The pharmacist placed a barrier next to the medicines counter so that access to this area was restricted.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available. There were several chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being overheard. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped and well screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. But the door could not be locked and there was an in-use sharps container on the floor. This was discussed with the pharmacist during the inspection, and she moved it to a more secure area.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It knows how to respond 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 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 pharmacist said that the pharmacy could produce large-print labels for people who needed them.

The pharmacist said that she would check 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 highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that prescriptions for Schedule 3 and 4 CDs were highlighted. And the date the medicines could not be collected after was recorded on the bag. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. There were storage instructions on the bags to help people store their medicines properly. The pharmacist said they checked CDs and fridge items 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 (PPP). Valproate medicines were only supplied in their original packaging which meant that people were provided with the relevant information. The pharmacist said that she would refer people to their GP if they needed to be on the PPP but weren't.

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 for the pharmacy to show what it had done in response. The pharmacist said that she would keep a record of the action taken in future. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every month and items due to expire within the next six months were clearly marked. There were no date-expired items found in with dispensing stock during a spot check and medicines were kept in their original packaging.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. The pharmacist said that she needed to order a denaturing kit 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 largely recorded. Some entries had not been signed to show that the medicines had been destroyed. The pharmacist said that these entries had been made before she started working at the pharmacy and she would try to find out whether the medicines had been destroyed.

Uncollected prescriptions were checked regularly. Items remaining uncollected after around six weeks were returned to dispensing stock where possible. And the prescriptions were returned to the NHS electronic system or to the prescriber. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacy supplied medicines to a few care homes and some of the residents had their medicines in multi-compartment compliance packs. The care homes were responsible for ordering prescriptions for their residents. The pharmacy received a list of items that had been requested and informed the care homes if any prescriptions had not been received as expected. Prescriptions were ordered in advance so that any issues could be addressed before people needed their medicines. There were no dispensed packs available on the day of the inspection. The pharmacist explained how the packs were assembled and the information on them.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible for CDs 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.

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 and separate liquid measures were marked for use with certain medicines only. 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 phone in the dispensary was portable so it could be taken to a more private area where needed.

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.