General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Charing Practice Ltd, 1 Surgery Close, Charing, ASHFORD, Kent, TN27 0AW

Pharmacy reference: 1032568

Type of pharmacy: Community

Date of inspection: 12/06/2019

Pharmacy context

The pharmacy is located within a surgery. The pharmacy received most of its prescriptions from the surgery as part of the dispensing doctors' practice. The people who use the pharmacy are mainly older people and younger families. The pharmacy provides a range of services including Medicines Use Reviews, the New Medicine Service, smoking cessation, weight management and a warfarin clinic. It provides multi-compartment compliance aids to around 80 people who live in their own homes to help them take their medicines safely. And it supplies medicines to one care home with around 30 residents.

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 generally identifies and manages the risks associated with its services. It largely protects people's personal information. It actively seeks feedback from the public and makes changes to help improve services. It generally keeps its records up to date. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some 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. Near misses were recorded and reviewed regularly for trends and patterns. The pharmacy technician said that these were discussed during the weekly pharmacy meeting. She said that the superintendent (SI) pharmacist had informed the team that there had been fewer near misses recently. There had been an increase during, and immediately following, a recent refit and installation of a new dispensing robot.

Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The pharmacist said that it had been entered incorrectly onto the patient's medication record and the label matched the medicine supplied, but it was not the same as what was written on the prescription. Team members were reminded to carry out a three-way check using the prescription, label and product during the dispensing and checking process.

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. There were several baskets on the work surfaces. This limited the amount of available space for dispensing. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. A quad stamp was printed on prescriptions and dispensing tokens; staff initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). The pharmacy technician (accuracy checking technician (ACT)) knew which prescriptions she could check and knew that she could not check ones if she had been involved in the dispensing of the medicines.

Team members' roles and responsibilities were specified in the SOPs. The ACT thought that she could sell general sales list medicines if the pharmacist had not turned up. The inspector reminded the team what they could and couldn't do if the pharmacist had not turned up. She knew that she should not carry out dispensing tasks for pharmacy prescriptions. But said that she could dispense prescriptions from the dispensing doctors practice. The MCA said that she would not hand out bagged items or sell pharmacy-only-medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance in place. 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 special was made. The prescriber's and patient's details were not recorded in the private prescription record. And

the date on the prescription was not recorded. The pharmacist said that she would ensure that these were recorded correctly. The emergency supply record was completed correctly.

Controlled drug (CD) running balances were checked around once a week. The recorded quantity of one item checked at random was the same as the physical amount of stock available. There were two responsible pharmacist (RP) logs present; one in electronic format and one on paper. The electronic record was accurate for the day of the inspection. But there were several errors in both the electronic and paper versions. On several occasions, the pharmacist had not recorded when they ceased to be RP on the electronic record. And the paper record had several days where no RP had been recorded. The pharmacist said that she would ensure that one record was used and completed correctly. The correct RP notice was not displayed at the start of the inspection. The RP changed the notice so that her details were clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items awaiting collection could not be viewed by people using the pharmacy. The pharmacy technician said that team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 survey were available on the NHS website. A complaints procedure was available for team members to follow if needed. The dispenser said that there had been several complaints recently due to the increased waiting times. There had been some issues with the new dispensing robot and during the refit. Team members worked evenings, weekends and bank holidays to catch up on the backlog of prescriptions for a few months after the refit was completed. The pharmacy had also changed the way bagged items awaiting collection were kept. A new prescription retrieval system had been implemented. The pharmacist said that this had made it easier for team members to locate bagged items.

The pharmacist and other support staff had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The ACT could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She said that one of the doctors in the surgery was the safeguarding lead. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that she was not aware of any safeguarding concerns since she started working at the pharmacy around two years ago.

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. They can raise any concerns or make suggestions and have regular meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one regular pharmacist, one locum pharmacist, one ACT, one dispenser, one trainee dispenser, one MCA and two trainee MCAs working during the inspection. The team members wore smart uniforms. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. All trainee members of the team were enrolled on an accredited pharmacy course. The ACT said in the last two years around nine members staff had left and not all had been replaced. She said that the pharmacy was in the process of recruiting two part-time dispensers.

The trainee MCA appeared confident when speaking with people. She said that she would seek advice from another member of the team before selling any medicine. The MCA was not aware of the restrictions on sales of pseudoephedrine containing products. But she said that she would refer to the pharmacist if a person requested to purchase two boxes of pharmacy only medicines. The ACT confirmed that 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.

Team members had access to online training modules via the Invicta Health Learning Pool. The ACT said that certificates were issued for all completed training. Each team member kept a copy of the certificates in their training record folder. Some training was mandatory, and records were kept by the surgery practice manager. Team members said that training was currently carried out in their own time rather than in work time. The pharmacist said that once the pharmacy was ahead with prescriptions then team members should be allowed one hour each week to complete training during the working day. The pharmacist had completed a declaration of competence and consultation skills training for the services she carried out. The pharmacist said that three of the regular pharmacists had completed the required training to provide the influenza vaccination service. The pharmacist was enrolled on the CPPE Foundation Pharmacist Pathway. The pharmacists and pharmacy technician were aware of the revalidation process and had submitted continued professional development records for review.

The pharmacist said that there were weekly meetings to discuss any issues. A communication book was used to record any issues they wished to discuss. The ACT said that she felt comfortable to discuss any issues with the pharmacist. The pharmacist had completed her pre-registration year at the pharmacy. The current SI had worked at the pharmacy for around nine months and became SI in January 2019. Team members said that they had not had performance reviews or appraisals within the last three years.

Targets were not set for Medicines Use Reviews and the New Medicine Service. The pharmacist said

that she carried out these services for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But more could be done to ensure that people’s information and medicines are protected from unauthorised access at all times.

Inspector's evidence

The pharmacy was secured from unauthorised access. Swing-doors were used to restrict unauthorised access behind the counter. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy only medicines were kept behind the counter. The pharmacist did not have a clear view of the medicines counter from the dispensary. She could not listen to conversations at the counter. This meant that some opportunities for her to intervene may be missed. The pharmacist said that there used to be a clear view from the dispensary. But this had been changed during the recent refit. She said that there had been plans for a dispenser and pharmacist to work at the medicines counter. But there were currently not enough team members for this to be implemented. Air-conditioning was available; the room temperature was suitable for storing medicines.

There were three chairs in the pharmacy waiting area and additional seating was available in the surgery waiting area adjacent to the pharmacy. There were finned sections at the counter to help protect people’s privacy.

The two consultation rooms were accessible from the shop area. The rooms were not kept locked when not in use. Not all items inside were kept securely. The pharmacist said that she would ensure that the rooms were kept locked. Low-level conversations in the consultation rooms could not be heard from the shop area. The doors to both rooms were made from frosted glass which restricted view into the rooms from the shop area. There were two chairs and a desk available in each room. And they were accessible to wheelchair users.

The second consultation room was used by the surgery prescription clerk. Not all items were kept securely. One of the doors could be covered with a blind but the one to the dispensary was see-through. This may pose a risk to privacy, particularly if a person removed an item of clothing. 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

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe to use.

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. A variety of patient information leaflets were available. Services and opening times were clearly advertised. Team members thought that there was an induction hearing loop available. But this could not be located during the inspection. The dispenser said that it may have been misplaced during the refit.

The pharmacist said that she checked the monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. She had access to the surgery patient's medical records and could check results for most people. Prescriptions for these medicines were not highlighted so there is potential that the opportunity to speak with these people is missed. The pharmacy carried out blood tests for some people taking warfarin. The pharmacist said that results were recorded on 'INR Star' and reviewed by the pharmacist who had carried out the test. The pharmacist said that bagged items with schedule 3 or 4 CDs were highlighted with the expiry date of the prescription. There were no bagged items found for these items during the inspection. The pharmacist said that team members checked CDs and fridge items with people when handing them out. She said that the pharmacy supplied valproate medicines to a few patients. But it did not have the patient information leaflets or warning cards available. She said that she would order replacements from the manufacturer. There were currently no people in the at-risk-group who needed to be on the Pregnancy Prevention Programme.

Stock was stored in an organised manner in the dispensary and in the dispensing robot. Expiry dates for items not in the robot were checked every three months and this activity was recorded. The trainee dispenser said that items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock. But there was a bottle of tablets that were due to expire at the end of June 2019 found with dispensing stock and it was not marked. There were a few strips of medicines not in their original packaging and one strip did not have the batch number and expiry date recorded. An uncollected box of medicines had been placed with dispensing stock. But it did not have the batch number or expiry date recorded. The pharmacist said that she would remind team members to ensure that medicines were kept in suitably labelled containers. There were many medicines waiting to be put back into the robot on the day of inspection, but team members said that they did not have time to complete this task.

The trainee dispenser said that part-dispensed prescriptions were checked daily. 'Owings' notes were provided and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the items were collected. Uncollected prescriptions were checked monthly. Items uncollected after around four weeks were returned to dispensing stock where possible. And the patient's medication record was

updated. Prescriptions were kept at the pharmacy until they had expired so that the items could be re-dispensed if needed. The pharmacist said that the SI was considering implementing a text message reminder service.

Prescriptions for people receiving their medicines in multi-compartment compliance aids were ordered in advance so that any issues could be addressed before they 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. The pharmacy kept a record for each person which included any changes to their medication. They also kept hospital discharge letters for future reference. Compliance aids were suitably labelled and there was an audit trail to show who had dispensed and checked each compliance aid. Medication descriptions were put on the compliance aids. Patient information leaflets (PILs) were routinely supplied. The care home team were responsible for ordering prescriptions for their residents. The pharmacy was in regular contact with the care home and medicines management team. The two ACTs managed the compliance aids and these were assembled on a Monday and Tuesday. This posed issues when there was a bank holiday. The ACT said that she would consider changing the days the compliance aids were assembled so that these would be completed without the additional workload over the bank holiday periods. She said that two ACTs managed the system and they were productive in that two compliance aids could be assembled and then checked by the other ACT. This ensured that the workload was well managed.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs 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 a delivery driver. The pharmacist said that the driver took prescriptions with him to obtain people's signatures where possible. This could possibly increase the chance of these being misplaced. A delivery book was also used. But this was not used to record signatures. The pharmacist said that she would ensure that the delivery book was used and prescriptions kept at the pharmacy.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. A record of any action taken was kept showing what it had done in response.

The pharmacy had the equipment in preparation for the implementation of the EU Falsified Medicines Directive. But team members said that they had not received training and the equipment was not in use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

The carbon monoxide testing equipment was calibrated by an outside agency. The weighing scales and shredder were in good working order. The phone in the dispensary was not portable. But people in the shop area could not hear conversations in the dispensary. The dispenser was not aware that there was an ‘on hold’ button on the phone so people on the other end could potentially listen to conversations in the dispensary if this was not pressed. The pharmacist said that she would remind team members to use this when away from the phone.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were generally within the recommended range. Any times the temperature went out of range, it was re-checked and a record was made. The fridges were suitable for storing medicines and they 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.