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: 26/11/2024

Pharmacy context

The pharmacy is located within a surgery in a largely residential area. It provides NHS dispensing services, the New Medicine Service, flu vaccinations, blood pressure checks, smoking cessation and the NHS Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. It has an automated prescription collection point. And it receives most of its prescriptions from the surgery as part of the dispensing doctor's practice.

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	1.2	Good practice	The pharmacy team records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk.
2. Staff	Standards met	2.4	Good practice	The pharmacy encourages team members to be open and honest about their mistakes. And it provides them with tools to help minimise the chance of mistakes being repeated.
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 identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. The pharmacy protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. It largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

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. And team members' roles and responsibilities were specified in the SOPs. Team members said that the pharmacy would not open if the pharmacist had not turned up in the morning. And they said that the pharmacy would close if the responsible pharmacist (RP) had to leave the pharmacy and there was no second pharmacist available.

The pharmacist highlighted near misses (dispensing mistakes identified before the medicine had reached a person) with the team member involved at the time of the incident. And once a mistake was highlighted, team members were responsible for identifying and rectifying it. If a team member made several similar mistakes, they had to complete a three-way check practice matrix during the dispensing process. They recorded when they had completed each of the dispensing tasks, including checked the prescription against the label and product. This encouraged them to follow the correct dispensing process and not rush their work. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. The pharmacy recorded dispensing errors (dispensing mistakes that had reached a person) on a designated form and undertook root cause analysis. A recent error had occurred where a medicine was supplied to the wrong person. Team members discussed the incident and were reminded to check prescriptions against medicine labels when bagging items. The pharmacy completed monthly patient safety reviews and produced an action plan. The safety review included a near miss analysis, any other pharmacy issues, learnings from dispensing incidents, drug recalls and long term out of stock. All team members had to read the safety review and sign to show that they had understood it. Following a review, team members were reminded not to stack baskets too high and allow the pharmacists to catch up with checking medicines before dispensing more.

The pharmacy had current professional indemnity insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The superintendent pharmacist (SI) couldn't access the electronic private prescription records during the inspection. Following the inspection, he confirmed that he had contacted the software provider and the records were now available and contained all the required information. The SI said that the pharmacy had not needed to supply any prescription-only medicines in an emergency without a prescription. He explained that the pharmacy was open at the same time as the surgery and people who ran out of medicines were signposted to request a prescription from their GP. The correct RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several

occasions where the RP had not recorded when they had finished their shift. The SI said that he would ensure that the RP record was completed correctly in future.

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

The complaints procedure was available for team members to follow if needed and details about it were available on the surgery's website. The SI said that there had been a recent complaint where a person had not been notified that their medicines were ready to collect from the collection point. He explained that team members had received additional training to ensure that people received a text when their medicines were available to collect. And a note had been put on the patient's medication record.

The pharmacists had completed level 3 training about protecting vulnerable people. And other team members had completed safeguarding training provided by the pharmacy. Team members described potential signs that might indicate a safeguarding concern and how they would refer any concerns to one of the pharmacists. The SI said that there had not been any safeguarding concerns at the pharmacy. The pharmacy displayed contact details for the relevant safeguard authorities on the notice board in the dispensary for team members to refer to if needed. And the SI explained that there was a safeguarding lead at the surgery.

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. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists, six trained dispensers, one trained medicines counter assistant (MCA) and two trainee MCAs working during on the day of the inspection. Holidays were staggered to ensure that there were enough staff to provide cover and there were contingency arrangements for pharmacist cover if needed. The team members wore smart uniforms with name badges displaying their role. They 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.

Team members appeared to be confident when speaking with people. And they asked people relevant questions to establish whether the medicines they sold were suitable for the person they were intended for. One trainee MCA, when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. 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 mentioned that she had recently referred to the pharmacist when a person had asked to purchase a pharmacy-only medicine for their pet.

The pharmacists were aware of the continuing professional development requirement for professional revalidation. They had completed declarations of competence and consultation skills for the services offered and had done the associated training. They had recently completed training for the NHS Pharmacy First service and were in the process of undertaking training for the NHS Discharge Medicines Service. The pharmacists felt able to make professional decisions. Other team members completed training on a regular basis, and this was monitored by the SI. Training could be completed at work and team members were allowed regular protected training time.

The pharmacy team held a weekly meeting every Monday morning when the pharmacy was closed. Team members discussed such things as any issues, general feedback, and the recent patient safety review. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They had yearly performance reviews, and these were documented. The SI had written role profiles for each team member detailing their responsibilities, accountabilities, Key performance indicators and measures for success. And they each had a performance plan specific to their role.

Targets were set for the New Medicine Service. The SI explained that forms for the service were completed before the person collected their medicines so that people were not delayed in the pharmacy. He said that this had increased the number of people using this service. The SI said that services were provided for the benefit of the people using the pharmacy and he would not let the targets affect team member's professional judgement.

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 bright, clean, and tidy throughout which presented a professional image. It was secured against unauthorised access and pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

There was seating in the shop area for people to use while waiting for services. The consultation room was accessible to wheelchair users, and it was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. And there was an anaphylaxis kit available. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy provides its services safely and manages them well. It gets its medicines from licensed wholesalers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines. And people who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised at the pharmacy and on the surgery's website. The induction hearing loop appeared to be in good working order. And a variety of health information leaflets were available. Staff had been trained on how to operate the automated collection point. And the SI explained that the collection point sent regular text message reminders to people to let them know that their medicines were ready to be collected. He said that there had been a recent issue where a bag label had remained in the machine after some medicines had been collected so that the next person could not access their medicines. He said that the pharmacy now used differed bag labels, and these were taped to the bags.

The pharmacy used a dispensing robot to dispense some medicines. The SI explained that engineers could access the robot remotely to attempt to resolve any issues promptly. Or they usually attended the following day if there were any issues that could not be resolved remotely. He explained that team members could manually dispense from the robot if needed. And short-dated medicines were removed from the robot before they were due to expire.

Workspace in the dispensary was largely free from clutter and there were cleared spaces for dispensing and checking medicines. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks. A quad stamp was printed on prescriptions and dispensing tokens. Team members initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). This helped ensure that team members knew which prescriptions had been clinically checked.

There were signed in-date patient group directions available for the relevant services offered. 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 the surgery would not issue a prescription for a person taking a higher-risk medicine if they did not have recent blood test results available. Prescriptions for Schedule 3 and 4 CDs were highlighted which 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. And the RP said that team members checked CDs with people when handing them out. 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). The pharmacy dispensed these medicines in their original packaging. And the RP said that people would be referred to their GP if they needed to be on the PPP and weren't on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The SI explained the action the pharmacy took in response to any alerts or recalls. 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. Stock was stored in an organised manner in the dispensary and in the dispensing robot. Expiry dates were checked every three months and this activity was recorded. And short-dated items were highlighted. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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 largely within the recommended range. The fridges were suitable for storing medicines and were not overstocked. A data logger was used which showed how long medicines had been outside the appropriate range.

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. And prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The SI said that the pharmacy had a good working relationship with the surgery and informed GPs when medicines were out of stock so that the prescribers could prescriber alternative medicines. This helped to minimise the chance of an out-of-stock medicine being prescribed. People were sent a text message informing them that their medicines were available for collection. Uncollected prescriptions were checked weekly, and people were sent a text message reminder if they had not collected their items after around three weeks. 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 multi-compartment compliance packs to some people. A suitability assessment was completed by the person's GP to identify which medicines were needed to be dispensed into the packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. People were responsible for requesting prescriptions for their 'when required' medicines when they needed them. 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 dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines. Team members wore gloves when handling medicines that were placed in these packs. And packs were assembled in a room separate to the main dispensary to help minimise distractions. A wall planner was used, and team members marked when the prescription had been issued and signed. And when the labels had been created, the packs dispensed and checked. This meant that there was a clear audit trail to show when these tasks had been completed.

Deliveries were made by a delivery driver. 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. And 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 used to measure certain medicines only. Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only which 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. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Up-to-date reference sources were available in the pharmacy and online. The SI said that the blood pressure monitor had been in use for around two years, and it would be replaced in line with the manufacturer’s guidance. The carbon monoxide testing machine had been in use for less than four months and was calibrated by an outside agency when needed. Otoscope and thermometer were cleaned after each use and disposable tips used. And the weighing scales were 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.