General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Belvedere Pharmacy (MECKAY LTD), 11 Picardy Street, BELVEDERE, Kent, DA17 5QQ

Pharmacy reference: 1032603

Type of pharmacy: Community

Date of inspection: 13/03/2023

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. It provides a range of services, including the New Medicine Service, needle exchange, blood pressure checks, flu vaccinations and COVID vaccination service. And it 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 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. Team members learn from mistakes that happen during the dispensing process. And they are aware of their responsibilities to ensure that vulnerable people are safeguarded. The pharmacy largely protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy keeps most of its records up to date and accurate.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs). Some team members had signed to show that they had read, understood, and agreed to follow the SOPs. The pharmacy technician said that he would ensure that other team members had also read them. One of the team explained that the pharmacist would let them know if they had made a dispensing mistake which was identified before the medicine had reached a person. He said that he would then have to identify and rectify the mistake. The pharmacy kept a record of these dispensing mistakes and reviewed them regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacy technician explained how the pharmacy dealt with any dispensing errors, where a dispensing mistake had reached a person. He said that a record would be kept, and a root cause analysis would be undertaken. He said that he was not aware of any recent dispensing errors.

There were clear workspaces in the dispensary for dispensing and checking medicines. And team members used baskets during the dispensing processed to help minimise the chance of medicines being transferred to a different prescription. The pharmacy technician said that team members usually initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. But there were some items which had been dispensed on Saturday and the labels had not been initialled. The pharmacy technician said that he would remind team members to complete this task each time they had dispensed a medicine.

The pharmacy technician said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. He said that he would attempt to contact the pharmacist and signpost people to another pharmacy if needed. He knew that the pharmacy could not sell any pharmacy-only medicines or hand out dispensed items if the responsible pharmacist (RP) was not in the pharmacy. The complaints procedure was available for team members to follow if needed. The pharmacy kept a record of complaints received and any action that had been taken as a result of the complaint.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were several occasions where the RP had not completed the record when they had finished their shift and a different pharmacist was working the following day. The inspector discussed this with the pharmacist during the inspection. The private prescription records were largely 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. There were several private prescriptions from hospitals that did not have all the required information on them when the supply was made. The prescriptions stated that the person would have to take the request to their GP for a prescription to be written. The pharmacy

technician said that he would discuss these with the regular pharmacist. 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. The pharmacy technician said that he would ensure that this was recorded in future. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The CD running balance checks were carried out at regular intervals and any liquid overage was recorded in the register.

People using the pharmacy could not see information on the computer screens and computers were password protected. And the pharmacy shredded its confidential waste. Team members used their own NHS smart cards during the inspection, and these were stored securely when not in use. Bagged items waiting collection could not be viewed by people using the pharmacy. There was some patient information next to the areas where people would have to walk through the dispensary if they wanted to access the consultation room. The pharmacy technician said that he would ensure that this was removed before a person was allowed through the dispensary.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some training about safeguarding vulnerable people. Team members described the types of people who might be considered vulnerable. And said that they would refer any concerns to the pharmacist or pharmacy technician immediately. The pharmacy technician said 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 team members to provide its services safely. Team members are enrolled on appropriate courses promptly and they do the right training for their role. They can raise any concerns and have regular meetings. And their professional judgement is not affected by the pharmacy's targets.

Inspector's evidence

There was one locum pharmacist, one pharmacy technician and two apprentices working during the inspection. The apprentices were enrolled on accredited courses for their roles. Team members were observed to ask each other questions if they were unsure about something. And they sometimes checked with another team member when selecting a medicine to ensure that it was the right one before continuing to dispense it.

The apprentices appeared confident when speaking with people. One, when asked, said that he would refer to the pharmacist if a person asked to purchase more than one box of an over-the-counter medicine. He was aware which medicines which could be abused or may require additional care and would refer to the pharmacist if a person asked for these on a regular basis. And he knew which questions to ask to establish whether a medicine was suitable for the person they were intended for.

The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacy technician said that he and the pharmacist had completed the necessary training for the vaccination services offered. The pharmacy used the National Protocol for the COVID vaccination service. The pharmacy technician said that he had recently completed some training about the polio vaccine. And he had done some online training about Colif. He said that there was limited time for him to complete the training at work, so he usually did it in his own time at home. He said that the regular pharmacist passed on important information to team members about medicines or changes in regulatory matters.

The pharmacy technician said that there were informal team meetings to discuss any issues and tasks that needed to be completed. And team members would highlight any issues as soon as they became apparent during the say. The pharmacy technician said that team members had ongoing appraisals and the pharmacist would usually discuss any performance issues with team members at the time. Team members felt comfortable discussing any issues with the pharmacists. The pharmacist felt able to take professional decisions and said that he would let one of the regular pharmacists know about any issues.

Targets were set for some of the services and the pharmacy technician said that the targets were discussed at the team meetings. He said that he would not let the targets affect his professional judgement and provided the services for the benefit of the people using the pharmacy.

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. But the pharmacy could do more to keep some areas tidy and free from potential tripping hazards.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and generally tidy throughout. The pharmacy kept its pharmacy-only medicines behind the counter. And the pharmacist had a clear view of the medicines counter from where he checked medicines. This meant that he could hear conversations at the counter and could intervene when needed. The temperature in the pharmacy on the day of the inspection was suitable for storing medicines. And the pharmacy had air conditioning units available for use during the warmer months.

There were two chairs in the shop area for people to use while waiting. These were positioned near the main entrance to the pharmacy to help minimise the risk of conversations at the counter being heard. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

There were two consultation rooms to the rear of the pharmacy. The rooms could be accessed via the rear door to the pharmacy (mostly used for the vaccinations). The rooms were accessible to wheelchair users, suitably equipped and well-screened. There was an anaphylaxis kit readily available in the main consultation room. Conversations at a normal level of volume in the consultation room could not be heard from outside the rooms. There were several chairs for people to use outside the rooms and there were screens separating the chairs. The pharmacy technician explained that people would sometimes have to go through the dispensary if they wanted to use the consultation room. He said that a team member would always remain with them. There were some boxes on the walkway in the dispensary and these were potential tripping hazards. The pharmacy technician said that these would be moved, and the walkway kept clear in future.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy largely provides its services safely and manages them well. It gets its medicines from reputable suppliers, and generally stores them properly. But it doesn't always ensure that its medicines are kept in appropriately labelled containers. 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. A notice was displayed at the main entrance which directed people to the rear of the pharmacy if they were attending for a vaccination. 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. There was a clinical waste bin near the front of the pharmacy for people to return used sharps. Once the waste has been put in the bin, it could not then be retrieved without having the key to access it. This bin meant that team members did not have to handle returned sharps. There was a list of local walk-in centres on display in the shop area.

The pharmacy didn't highlight prescriptions for higher-risk medicines where additional counselling might be needed. Prescriptions for schedule 3 and 4 CDs were not always highlighted to alert team members about the shorter prescription validity. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacy technician said that he would remind team members to highlight these in future. A team member said that regular pharmacist spoke with people taking valproate medicines and discussed whether they needed to be on the Pregnancy Prevention Programme (PPP). And there were currently no people in the at-risk group who needed to be on a PPP. The pharmacy had the patient information leaflets, warning cards and warning stickers available for use with split packs.

The pharmacy technician 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. People let the pharmacy know if they needed their 'when required' medicines at the same time as their packs. The pharmacy kept a record for each person which included any changes to their medication. Packs were largely labelled correctly, but the cautionary and advisory warning labels were not on the packs and the patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacy technician said that he would ensure that the packs were suitably labelled, and the information leaflets supplied in future.

The pharmacy technician said that people were given an 'owing' note if the pharmacy was not able to dispense their prescription in full. He said that the pharmacy asked for prescriptions for alternate medicines where needed and people were kept informed about any supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy technician said that uncollected prescriptions were checked regularly, and items were returned to dispensing stock where possible if they had not been collected after around two or three months. The prescriptions for

these medicines would then be returned to the NHS electronic system or to the prescriber.

Stock was stored in an organised manner in the dispensary. Short-dated items were not highlighted and there were several expired medicines found in with dispensing stock. A few medicines found with dispensing stock were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. There were several boxes which contained mixed batches found with dispensing stock. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The pharmacy technician said that he would ensure that the date checking routine was more robust so that short-dated medicines could be more easily identified and removed before they had expired. And he said that he would remind team members to ensure medicines were kept in appropriately labelled packaging. The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy technician explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference.

The fridges would alarm if the temperature was outside the recommended range. They were suitable for storing medicines and were not overstocked. And the pharmacy temperatures were continually monitored, and records were kept to show that the temperatures remained within range. 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.

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. A separate liquid measure was 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 minimise the risk of cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacy technician said that the blood pressure monitor would be replaced in line with the manufacturer’s guidance. 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.

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.