General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Duncans Chemist, 24 Bromley Hill, Downham, BROMLEY, Kent, BR1 4JX

Pharmacy reference: 1032606

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

This is a community pharmacy in a parade of shops on a busy main road in a mainly residential area. There are two doctors' surgeries nearby. The pharmacy offers services such as Medicines Use Reviews, New Medicine Service checks, and travel vaccinations. It supplies medication in multi-compartment compliance packs to people who need help managing their medicines. People can ask to have their blood pressure checked.

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	2.2	Good practice	Team members are given regular ongoing training and get time set aside in work to do it. This helps them keep their knowledge and skills up to date.
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 manages the risks associated with its services well. Its team members have clear roles and responsibilities. They record and regularly review any mistakes that happen during the dispensing process to help make the pharmacy's services safer. The pharmacy largely keeps the records it needs to by law and it protects people's personal information properly. It asks people who use the pharmacy for their feedback. Team members know how to protect vulnerable people.

Inspector's evidence

Near misses were recorded on an ongoing basis in the dispensary and they were reviewed monthly to identify any patterns. When a near miss was identified, the pharmacist passed it back to the person who had dispensed it so that they could identify their own mistakes. The pharmacist described the incentive programme he had set up where team members were given 50p if a person consented to be signed up to the electronic prescription service. He said that if they made a near miss, this 50p was taken off. He said that the number of near misses had decreased since this system came into place. It was discussed with the pharmacist during the inspection how this could potentially disincentivise team members from recording any near misses they found themselves. Following the inspection, the superintendent pharmacist (SI) explained that team members still reported near misses openly after the incentive programme had come into place. She said that the pharmacist recorded the near misses. She provided records of recent reviews of near misses that had taken place, and these included graphs of numbers of near misses in each month, action to be taken as a result of different types of near misses, and any other issues discussed by the team. The reviews had been signed by team members to indicate that they had understood them.

Near misses were reviewed monthly to identify any patterns and the results from this review were discussed with the team members. A record of these discussions was not made. The pharmacist said that he had found a pattern of near misses where the wrong quantity had been dispensed. This was believed to have been caused by differing pack sizes arriving in for the same medicines, and the pharmacist had discussed it with the team members to make them more aware. The team had also noticed that the expiry dates on some medicines were written with the month rather than the day first. This had caused some issues when date-checking the stock, and the pharmacist said that this learning had been shared with the other branches. Team members showed medicines which looked or sounded alike had been separated on the shelves to help avoid picking errors.

Standardised forms were used to record dispensing errors and the pharmacist explained how he recorded them on the National Reporting and Learning System. He was not aware of any recent errors which had occurred. A range of standard operating procedures (SOPs) was in place, although the folder was a little disorganised and it was hard to find specific SOPs. Team members had signed the SOPs relevant to their roles to indicate that they had read and understood them. The pharmacist said that the pharmacy's head office was in the process of reviewing the SOPs. The trainee medicines counter assistant (MCA) was clear about her own role and responsibilities. She could describe what she could and couldn't do if the pharmacist was absent. But she thought that she could sell General Sales List medicines if the pharmacist had not turned up in the morning. The inspector reminded her of the requirements.

The pharmacy undertook an annual patient survey, and the results from the latest one were positive. Around 92% of respondents had rated the pharmacy overall as very good or excellent. Team members were familiar with the complaints procedure and said that they would refer any complaints to the pharmacist. A sign was in the shop area which informed people how they could provide feedback or raise concerns. The pharmacist said that the pharmacy had received complaints from people when their medicines were out of stock with the manufacturers. He said that the team had tried to address this by regularly checking with the manufacturers and giving people weekly updates. He said that he had referred some people back to their GP for an alternative medicine when the stock was still unavailable.

The pharmacy had an in-date indemnity insurance certificate. The right responsible pharmacist (RP) notice was displayed, and the RP log had been completed correctly. Private prescription records and unlicensed medicine records examined contained the required information. Most emergency supply records were complete, but some did not indicate the nature of the emergency. This could make it harder for the pharmacy to show why the supply was made in an emergency without a prescription. Controlled drug (CD) registers examined were largely maintained well, but there was a small amount of overwriting in places. CD running balances were usually checked weekly. A random check of a CD showed that the running balance matched the quantity in stock.

People's personal information was kept away from public view. A shredder was used to destroy confidential waste. Computer terminal screens were turned away from people using the pharmacy, and the computers were password protected. The pharmacist said that the pharmacy's information governance policy was at head office where it was being updated. He showed that team members had completed a test on the General Data Protection Regulation, and the results had been sent to head office. The pharmacist was observed asking people if they wanted to use the consultation room when selling medicines over the counter.

The pharmacist confirmed he had completed level 2 safeguarding training and was able to explain what he would do if he had any concerns. He knew where to find the contact details of local safeguarding agencies. Team members could say what they would do if they had any concerns about a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are given regular ongoing training and get time set aside in work to do it. This helps them keep their knowledge and skills up to date. They are encouraged to make suggestions to help improve the pharmacy's services. And they are comfortable about raising any concerns.

Inspector's evidence

At the time of the inspection there was one pharmacist, one pre-registration trainee (pre-reg), two trained dispensers, one trained medicines counter assistant (MCA), and one trainee MCA. Team members were able to explain what accredited training they had done or were undertaking. The pharmacist showed that the delivery drivers had also completed accredited MCA training, and they sometimes worked on the counter. The staff appeared organised during the inspection and communicated well with each other and dispensing was up to date.

The pre-reg had started work at the pharmacy just over a month ago. He felt well supported during his training and said that he had meetings with his tutor every week or fortnight. Team members had ongoing training, and the pre-reg was responsible for managing the training packages. The pharmacy had a pre-reg each year, and he or she took responsibility for managing the ongoing staff training. Team members said that the pre-reg picked a topic and went through it with them every month. Team members got time set aside at work to do training if there were any packages to complete, and records were kept of the training that had been completed.

Team members felt comfortable about raising any concerns or making suggestions. They said that there was an open and honest environment in the pharmacy and they had meetings with the superintendent pharmacist every fortnight or every month. They said that they were encouraged to make suggestions in these meetings. The dispenser gave an example of a discussion they had had about the staffing rota, and it was changed to help ensure that the extended opening hours were better covered. The pharmacist said that he had regular meetings with the superintendent pharmacist and was comfortable about discussing any issues that arose. Team members had some targets in place, but the pharmacist did not feel under any undue pressure to meet them. He said that he felt able to take professional decisions to ensure that people were kept safe.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and suitable for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The premises were clean and mostly tidy. There was a limited amount of clear workspace available but there was sufficient space to dispense safely. There was a stack of empty and full delivery boxes in the middle of the dispensary floor. And there were a few boxes of part-dispensed medicines on the floor. Team members explained that they were in the middle of making the monthly supply of medicines to a care home and that the dispensary floor was normally kept clear. They said that the dispensary would be tidied once the supply had been made.

The room temperature was suitable for the storage of medicines and was maintained with air conditioning. Handwashing facilities were available. The premises were secure from unauthorised access. The consultation room was relatively small, but it was generally clean and tidy. It allowed a conversation to take place inside which would not be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. It obtains its medicines from reputable sources and mostly manages them well. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access into the pharmacy from the street, and a list of services was displayed in the window. Several team members spoke other languages, and they said that this helped people accessing the services. The space in the shop area was large enough to help people with wheelchairs or pushchairs manoeuvre. The pharmacy offered a text messaging service to inform people when their medicines were ready to collect.

Baskets were used during the dispensing process to prevent people's medicines becoming mixed up. There was a clear workflow through the pharmacy. The pharmacy had the equipment to comply with the Falsified Medicines Directive (FMD). The pharmacist said that he was in the process of contacting the pharmacy's training provider to provide staff training for using the FMD system. He showed that there was a software module for FMD already on the pharmacy computer system.

Multi-compartment compliance packs were dispensed in two places. People who received their packs monthly had their packs dispensed at another local branch of the same pharmacy chain. People who received weekly packs had them dispensed by this pharmacy. The pharmacist showed that they obtained consent from people who had their medicines dispensed into packs, and this informed people that the packs may be dispensed by the other branch. Only one set of packs was available to be examined in the pharmacy. The medicines inside were not all labelled with a description, which could make it harder for the person or their carer to identify the medicines. The packs did not have patient information leaflets with them. The technician said that they usually included the leaflets and would ensure they were supplied in future. The packs were not labelled with the required warnings for certain medicines, and the technician said that he would discuss with the pharmacist how this could be done. The technician showed that the pharmacy kept notes of when there was communication with the prescriber, or when a medicine was stopped or changed. People were referred onto the compliance pack service by the Lewisham Integrated Medicines Optimisation Service (LIMOS). LIMOS assessed the person before referring them to the pharmacy and monitored how the person was managing their medicines on an ongoing basis.

Patient group directions (PGDs) were available electronically. Some of them were examined and they were in date, with the signed copies available. The pharmacist showed how they obtained patient consent when making supplies under PGDs.

Team members were aware of the additional guidance to be provided about pregnancy prevention to people taking valproate. They showed that they kept copies of the valproate cards and leaflets at each workstation and said that they supplied the cards to all females taking valproate. They said that the pharmacy did not currently have any people taking valproate in the at-risk group. The pharmacist described how he spoke with the care home manager to check people had received a recent blood test

before supplying medicines such as lithium or warfarin. He said that people who came to the pharmacy were asked for their INR reading if they were taking warfarin, but the readings were not always recorded on the computer. This could make it harder for the pharmacy to see what people's previous blood test results were. The pharmacist said that people taking warfarin were usually monitored by their GP or the local anticoagulant clinic. He showed how they highlighted bags of dispensed medicines where additional care was needed, such as with CDs, higher-risk medicines, new medicines, or dose changes. The pharmacist explained how he asked for the weight of people receiving paediatric medicines so that he could confirm the dose was appropriate.

An audit trail was used for deliveries of medicines to people's homes, and the recipients signed separate bag labels to indicate safe delivery. Team members said that if the person was not in, they left a slip requesting the person to contact the pharmacy.

Medicines were obtained from licenced wholesale dealers and specials suppliers. They were stored in an orderly manner in the dispensary. Date-checking was done regularly, and this activity was recorded. No out-of-date medicines were found on the shelves checked. Two boxes of medicines contained mixed batches, and this could make it harder for the pharmacy to appropriately date-check the stock or respond to safety alerts. The boxes were removed. Bulk liquids were marked with the date of opening so that staff knew if they were still suitable to use. Medicines for destruction were separated from stock and placed into designated destruction bins.

Medicines requiring cold storage were stored in two suitable fridges. The temperatures were monitored and recorded daily, and previous records showed that the temperatures had remained within the acceptable range. CDs were kept securely.

The pharmacy received drug alerts and recalls via email, and a record of the action taken was made. The pharmacist was aware of the recent recalls for bisacodyl and aripiprazole and said they had been actioned but was unable to locate the paperwork during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs for its services. It uses its equipment in a way which protects people's personal information.

Inspector's evidence

There were calibrated glass measures, and a separate marked one for use with liquid methadone. Tablet counting triangles were clean and a separate marked triangle was used for cytotoxic medications. This helped avoid cross-contamination. The electronic tablet counter had some tablet dust inside and this was cleaned during the inspection.

The blood pressure meter did not have a record of when it had been replaced or recalibrated. The pharmacist thought that it was around five or six years old and said he would replace it. Following the inspection, the SI confirmed that the meter was actually two to three years old and that it since been been replaced. The SI said that a record had been made of the date of first use for the new meter. The fax machine was away from the public area, and the cordless phone could be moved somewhere more private to protect people's personal information. Team members had access to up-to-date reference sources including the internet.

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.