General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Compact Chemist, 139 Blendon Road, BEXLEY, Kent, DA5 1BT

Pharmacy reference: 1032631

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 near to the A2. It provides a range of services, including the New Medicine Service and the flu vaccination service. It also 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 supplies medicines to a large number of care homes. It 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 records and regularly reviews any mistakes that happen during the dispensing process. And it protects people's personal information well. The pharmacy largely keeps its records up to date and accurate. People can feedback about the pharmacy's services. And team members know what to do to ensure that vulnerable people are protected.

Inspector's evidence

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. 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. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The accuracy checking dispenser said that she was not aware of any recent dispensing errors.

Workspace in the dispensary was free from clutter and 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 signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checking dispenser knew which prescriptions she could check and knew that she should not check any if she had been involved with the dispensing of the medicine.

The pharmacy had up to date, documented standard operating procedures (SOPs). Team members had signed to show that they had read and agreed to follow them. And they had to pass a test to show that they had understood them. The pharmacy's head office ensured that all team members had completed the tests. Team members' roles and responsibilities were specified in the SOPs. Team members said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. One was unsure about what tasks should not be undertaken if there was no responsible pharmacist (RP) signed in. They knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the RP was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked regularly. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's details were not routinely recorded. The pharmacist explained that the record was printed each month and the details written on before it was submitted to the pharmacy's head office. The pharmacist said that she would review this procedure to ensure that the record was completed within the required timeframe. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were a few occasions recently when the

pharmacist had not completed the record when they had finished their shift. This was discussed with the pharmacist during the inspection.

The pharmacy sent its confidential waste to the pharmacy's head office for appropriate disposal. Computers were password protected and the 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. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed. The accuracy checker said that she was not aware of any recent complaints. The pharmacist said that she would inform the pharmacy's head office if a person made a complaint.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed some safeguarding training provided by the pharmacy's head office. Team members knew who might be classed as vulnerable and said that they would refer any concerns to the pharmacist. The accuracy checking dispenser said that there had not been any safeguarding concerns at the pharmacy. And the pharmacy had contact details available for safeguarding agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They are given the opportunity to undertake some training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. And they 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 pharmacist, two trainee pharmacists, one trained accuracy checking dispenser, one apprentice and one trainee dispenser working during the inspection. Team members had either completed an accredited course for their role or they were enrolled on a suitable course. There were some unplanned staff absences on the day of the inspection which added to the workload pressures. And the team were prioritising tasks to ensure that people received their medicines when they needed them. The team worked hard to ensure that the deliveries were ready for the drivers on time. There had only been the pharmacist and one dispenser in the morning. The pharmacist had informed the pharmacy's head office and she was able to sort out extra staff for the afternoon. Team members worked well together to ensure that medicines were ready for the delivery drivers to take.

Team members appeared confident when speaking with people. The accuracy dispenser was aware of the restrictions on sales of pseudoephedrine-containing products. She knew which medicines could be misused or may require additional care. And would refer to the pharmacist if someone was asking to buy these medicines on a regular basis. She asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had recently undertaken some training about the administration of medicines for care homes. The pharmacist felt able to take professional decisions. And she had completed declarations of competence and consultation skills for the services offered, as well as associated training. The accuracy checker said that she had access to online training modules. And could do some training during the working day if the workload allowed. Team members could access the online training modules at home if they preferred.

Team members said that there were informal team meetings to allocate tasks and discuss any issues. And they discussed problems throughout the day as they arose. One of the team said that the pharmacy had recently started undertaking appraisals and performance reviews for staff. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they could speak with the pharmacy's head office directly if there were any issues with a locum pharmacist. Targets were not set for team members. The pharmacist said that the pharmacy provided the services for the benefit of the people who used 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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The room temperature on the day of the inspection was suitable for storing medicines and air conditioning was available. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

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. The window in the door was see-through. The pharmacist said that she would usually stand in front of the window to block the view if needed but would consider having this covered.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. But 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

Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access to the pharmacy through a wide entrance. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 CDs were highlighted. The pharmacist said that she would do the same for Schedule 4 CDs to help minimise the chance of these being handed out when the prescription was no longer valid. 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). The pharmacist said that the pharmacy had recently carried out an audit for people taking valproate medicines to ensure that everyone who needed to be on a PPP was on one. And she would refer people to their GP if they needed to be on one and weren't.

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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Short-dated items were marked and there were no expired medicines found in with the dispensing stock. Medicines were kept in their original packaging which helped the pharmacy to respond to safety alerts appropriately. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

Uncollected prescriptions were checked monthly. A team members said that she would attempt to contact people if the items had not been collected after one month, before returning the medicines to stock if possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber. Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy emailed the care homes as soon as any sock issues were identified so that they could manage them.

The pharmacist said that the pharmacy did not dispense medicines into multi-compartment compliance packs, and these were dispensed at the pharmacy's hub. She said that the pharmacy had not asked people for consent before sending their prescriptions to the hub. She said that she would discuss this with the pharmacy's head office. Following the inspection, the pharmacy's head office confirmed that people were sent a letter explaining that their prescriptions would be dispensed at the hub. And people could opt out of this by informing the team in-store. The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in the packs. This pharmacy ordered 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. Prescriptions for 'when required' medicines were not routinely requested, and a team member said that people asked for these when needed. The pharmacy kept a record for each person which included any changes to their medication. Cautionary and advisory warning labels were not recorded on the backing sheets. This could make it more difficult for people to know how to take their medicines safely. The pharmacist said that the packs received from the hub did not have the medication information leaflets provided so the pharmacy had to print these before the medicines were supplied. The pharmacist said that the pharmacy was not always able to provide the exact leaflet for the medicine as it didn't know the name of the manufacturer. The pharmacist said that she would contact the hub and request that the leaflets were supplied with the packs in future.

The pharmacist explained that the care homes were responsible for requesting the prescriptions for their residents. The pharmacy received the prescriptions and sent copies to the care home so that their team could ensure that the items received matched those requested. The pharmacy printed medication administration records for each resident, and these were sent to the care homes. The pharmacy mostly communicated with the care homes via email to ensure that there was an audit trail. The pharmacist said that the pharmacy undertook audits on the care homes to ensure that the medicines were being stored properly and administered safely.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was usually left at the address asking the person to contact the pharmacy to rearrange delivery. The pharmacist explained that one of the drivers only delivered to the care homes and the medicines for return were pre-arranged so that these were received into the pharmacy while it was open.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The accuracy checker 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.

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. 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.