General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bourne Road Pharmacy, 7 Bourne Parade, Bourne Road, BEXLEY, Kent, DA5 1LQ

Pharmacy reference: 1032632

Type of pharmacy: Community

Date of inspection: 28/08/2020

Pharmacy context

The pharmacy is located on a parade of shops surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including the New Medicine Service. It supplies medication in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. The inspection was carried out during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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. It regularly seeks feedback from people who use the pharmacy and team members understand their role in protecting vulnerable people. The pharmacy protects people’s personal information. And it largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. Documented standard operating procedures (SOPs) were available and team members had signed to indicate that they had read and understood these. The pharmacist said that the pharmacy was in the process of carrying out workplace risk assessments in relation to Covid-19.

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. Team members identified and rectified their own mistakes and recorded them. The near misses were reviewed regularly for patterns. Medicines in similar packaging or with similar names were separated where possible. The pharmacist said that he was not aware of any recent dispensing errors where a dispensing mistake had reached a person. He said that these would be recorded and a root cause analysis would be undertaken.

Workspace in the dispensary was free from clutter. 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. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The trainee dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. She confirmed that she would not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. 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 nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The private prescription record was largely completed correctly. But the prescriber’s details and the patient’s address were not always recorded. There were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that he would ensure that this information was checked in future. And he said that he would ensure that the private prescription and emergency supply records had all the relevant information recorded in the future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Bagged items waiting collection could not be viewed by people using the pharmacy. Team members used their own smartcards to access the NHS electronic services and these were stored securely when not in use.

The pharmacy carried out patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were generally positive and people who responded to the survey were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that he was not aware of any recent complaints.

The pharmacist and pharmacy student had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The pharmacist said that the trainee dispenser would complete some safeguarding training after her probation period. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and she said that she would refer any concerns to the pharmacist. The pharmacist 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. They can raise any concerns or make suggestions. The pharmacy has recently introduced ongoing training support for its staff. But the current workload has affected the teams ability to access this training. This could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one pharmacist, one pharmacy student and one trainee dispenser working during the inspection. The pharmacy student said that he had completed the pharmacy degree and was working at the pharmacy to gain experience. The trainee dispenser had worked at the pharmacy for around two months. The pharmacist said that the trainee dispenser would be enrolled on an accredited course within the required timeframe. The team worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispenser appeared confident when speaking with people. She said that she would refer to the pharmacist if someone asked to purchase more than one box of pseudoephedrine-containing products. And she also 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.

The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. He said that he had recently completed some training about the coronavirus. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus. The pharmacy had access to online training modules provided by another company. The pharmacist said that this had been recently implemented and team members would start to complete the training modules when the workload was more manageable. But at the time of the inspection, team members were not undertaking any ongoing training.

Team members said that they felt comfortable about discussing any issues with the pharmacist or any concerns. The pharmacy student said that the pharmacist had carried out an informal appraisal and performance review but this had not been documented. Targets were not set for team members. The pharmacist said that services were provided 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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available; the room temperature was suitable for storing medicines. A screen had been installed at the medicines counter to help minimise the risk of spreading Covid-19. A one-way system and floor markings had been implemented to help people to keep a suitable distance from each other.

There was a small padded bench in the shop area for people to use while they waited. This was positioned near to the medicines counter and conversations at the counter could clearly be heard. The consultation room was not accessible to wheelchair users and the room was currently being used as storage. The door from the consultation room to the shop area was kept locked when not in use. The pharmacy was limiting the number of people in the shop area and there was opportunity to speak to people in an area of the shop which was out of the way. Low-level conversations in the consultation room could not be heard from the shop area and the windows were covered. 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

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them appropriately. It takes the right action in response to safety alerts, so that people get medicines and devices that are safe to use. 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. It doesn't always keep prescriptions at the pharmacy until the medicines have been collected. And this may make it harder for team members to refer to the original prescription and may increase the chance of errors.

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. Services and opening times were clearly advertised and a variety of health information leaflets were available.

Prescriptions for higher-risk medicines such as methotrexate and warfarin were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The trainee dispenser was unsure how long some prescriptions were valid for. The pharmacist said that he would ensure that prescriptions for higher-risk medicines and Schedule 3 and 4 CDs were highlighted in future. The pharmacy student 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. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked at regular intervals and this was recorded. Some short-dated items had been marked but this was not consistent throughout. The pharmacist said that he would remind team members to highlight these in the future to help minimise the chance of them being handed out. The inspector didn't find any out-of-date medicines with dispensing stock.

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. But prescriptions were not always kept at the pharmacy until the remainder was dispensed. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of errors. The pharmacist said that he would ensure that prescriptions were kept at the pharmacy until the medicines were collected in the future. The pharmacy student said that uncollected prescriptions were checked regularly and any which remained uncollected after around three months were returned to dispensing stock where possible. There were several prescriptions in the retrieval system which had expired and some items waiting collection did not have the prescription attached. The pharmacist said that uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out by their GP if they asked to have their

medicines dispensed into multi-compartment compliance packs. Prescriptions for people receiving these 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. The pharmacy student said that people usually contacted the pharmacy when they needed them with their packs each month. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each tray. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people have up-to-date information about how to take their medicines safely. The trainee dispenser said that she would ensure that these were routinely provided in the future.

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 kept separate. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver and the pharmacy student. The student said that he did not currently ask people for signatures to help minimise the spread of infection. He said that he knocked on the person's door and placed the items on the step before stepping back. He explained that he asked people to confirm their details before leaving the items with them. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacy kept a copy of drug alerts and recalls for future reference and it recorded any action taken to show what it had done in response. The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive. Team members had received training on how to use the equipment and it was being used when possible.

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 medicines was available and clean. Triangle tablet counters were available and a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order and the phone in the dispensary was portable so it could be taken to a more private area where needed.

Masks, aprons, gloves and hand sanitiser was available for team members and people who used the pharmacy. Team members wore masks throughout the inspection.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records showed that the temperatures were consistently within the recommended range.

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.