General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cheadles Chemist, 68 St.Dunstans Street, CANTERBURY, Kent, CT2 8BN

Pharmacy reference: 1032651

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre surrounded by residential premises. The people who use the pharmacy are mainly older people and university students. The pharmacy receives around 95% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service (NMS). It provides multi-compartment compliance aids to around 20 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to around 20 people.

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

The pharmacy generally identifies and manages the risks associated with its services. It generally protects people's personal information. It actively seeks feedback from people who use the pharmacy. And it mostly keeps its records up to date. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. The pharmacy had up-to-date standard operating procedures (SOPs). Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded on the computer and team members reflected on how the mistake happened. There were very few recorded near misses. The pharmacist said this was due to having qualified members of staff and how the workload was organised. Medicines with similar names were separated where possible. The pharmacist said that she was not aware of any dispensing incidents at the pharmacy. She confirmed that she would record any incidents on the computer, complete a root cause analysis and report it to head office.

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.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) knew that she should not hand out bagged items or sell pharmacy only medicines if the pharmacist was not in the pharmacy. The dispenser knew that he should not carry out dispensing tasks if the pharmacist had not turned up. He said that the pharmacy would remain closed.

The pharmacy had current professional indemnity and public liability insurance in place. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. The prescriber's name was not recorded in the private prescription record. The dispenser said that he would ensure that this was included in future. The pharmacy did not send private prescriptions for controlled drugs (CDs) to the NHS. The pharmacist said that she would ensure that these were sent.

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 pharmacist said that she would ensure that this was recorded. CD running balances were checked around once a week. The recorded quantity of one item checked at random was the same as the physical amount of stock available.

The responsible pharmacist (RP) log was largely completed correctly. But there were a few occasions recently where the locum pharmacists had not signed out and there was a different pharmacist working the following day. This could make it more difficult to identify the pharmacist on a given day if there was a query. The correct RP notice was clearly displayed.

Confidential waste was removed by a specialist waste contractor for 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. Bagged items waiting collection could not be viewed by people using the pharmacy. Some team members had completed General Data Protection Regulation training. But the MCA said that she had not yet completed it.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were not available on the NHS website. But results from the 2017 to 2018 survey were available. Results from that survey showed that 98% of respondents were satisfied with the pharmacy overall. The complaints procedure was available and displayed in the dispensary. The pharmacist said that she was not aware of any complaints at the pharmacy since she started working there around one year ago.

The pharmacist and dispenser had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The MCA said that she had not received any safeguarding training. But she could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And she 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 trained team members to provide its services safely. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. The team members 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, one dispenser and one MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She said 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.

Team members had completed accredited pharmacy courses. The dispenser had completed the NVQ level 2 dispenser course. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. The dispenser had completed healthy living training and he was the Healthy Living Champion for the pharmacy. The MCA said that she had completed some recent training about vitamins and some other medicines. Team members had completed some training about the electronic repeat dispensing system. This had been provided by an outside organisation.

The pharmacist said that information was passed on informally and there were no regular formal meetings held. Team members underwent regular performance reviews and appraisals. The pharmacist said that she was due to have hers soon. And this would be carried out by one of the managers at head office.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that she did not feel under pressure to reach the targets. And she carried out these services for the benefit of the people using the pharmacy. She confirmed that she would not let the targets affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally 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; this presented a professional image. Pharmacy only medicines were kept behind the counter. But there was no barrier to restrict access to people using the pharmacy. Air-conditioning was not available; the room temperature was suitable for storing medicines on the day of the inspection.

There were two chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was accessible from the shop area. The room was kept locked when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The window in the doors was not see-through. There were two chairs and a desk available. The room was accessible to wheelchair users. And it was suitable for the services offered. There was a small sink. 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

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls adequately. This helps make sure that its medicines and devices are safe to use.

Inspector's evidence

There was a small step up into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and dispensary and could help people into the premises where needed. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. A record of results was generally kept on the patient's medication record. Prescriptions for these medicines were highlighted so there was opportunity for the pharmacist to speak with people taking these medicines. Prescriptions for schedule 3 and 4 CDs were highlighted. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few patients who may become pregnant. But she was not aware that the warning card had to be provided to all patients in the at-risk group every time they were supplied with the medicine. The pharmacy had the patient information leaflets or warning cards available. The pharmacist said that she would ensure that these were supplied to people who needed them. There were currently no patients who needed to be on the Pregnancy Prevention Programme.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. Short-dated stock lists were kept. And items were removed from dispensing stock at least one month before they were due to expire. There were no date-expired items found in with dispensing stock. Medicines were kept in appropriately labelled containers.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the medicines were collected. Uncollected prescriptions were checked monthly. Items uncollected after eight weeks were returned to dispensing stock where possible. A record of uncollected items was kept at the pharmacy. Prescriptions were either returned to the prescriber or returned to the NHS spine. Those returned to the NHS spine could be re-dispensed if the person went to the pharmacy to collect their medicines. The pharmacist said that she sometimes contacted people to ask if they still required their medicines before returning them to stock.

Prescriptions for people receiving their medicines in multi-compartment compliance aids were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that the pharmacy contacted people to ask if they needed them. The pharmacy kept a record for each patient which

included any changes to their medication. They also kept hospital discharge letters for future reference. Backing sheets were attached to the compliance aids and there was an audit trail to show who had dispensed and checked each compliance aid. 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 she would contact the system provider so that they could be added to the backing sheets. Medication descriptions were put on the packs. The pharmacist said that patient information leaflets (PILs) were routinely supplied.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver three days a week. The pharmacy obtained people's signatures for deliveries where possible. There were multiple details on each page. This could make it harder for the driver to ensure that people's personal details were protected. The pharmacist said that she would ensure there was a system in place to record people's signatures without disclosing another person's information. She contacted people to ensure that they would be at home to accept their medicines before the pharmacy attempted to deliver them.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from head office. A record of any action taken was kept for future reference to show what it had done in response.

The pharmacy had the equipment for the implementation of the EU Falsified Medicines Directive. But this was not installed. Team members said that they had not received training about how to use the equipment.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. A plastic measure was used for CDs. The pharmacist said that she had requested replacement measures which were suitable several times, but these had not been received. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

The pharmacist said that the blood pressure monitor had been in use around two months. The phone in the dispensary was portable so could be taken to a more private area where needed. Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and was not overstocked.

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.