General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Pharmacy, High Street, Goudhurst, CRANBROOK, Kent, TN17 1AG

Pharmacy reference: 1032688

Type of pharmacy: Community

Date of inspection: 20/06/2022

Pharmacy context

The pharmacy near a GP practice in a small village. It receives most of its prescriptions electronically from the practice. And it provides a range of services, including NHS dispensing, the New Medicine Service and flu vaccinations (seasonal). It also provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines.

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

The pharmacy identifies and manages the risks associated with its services to help provide them safely. And it reviews mistakes made during the dispensing process which helps the pharmacy to make its services safer and reduce any future risk. The pharmacy protects people's personal information. And it advertises how people can provide feedback about the pharmacy. Team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records accurate and up to date.

Inspector's evidence

The pharmacy had measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. 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 these were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that there had not been any recent dispensing incidents, where a dispensing mistake had reached a person. He explained that an incident report form would be completed and a root cause analysis would be carried out.

Workspace in the dispensary was free from clutter and there was an organised workflow which helped staff to prioritise tasks and manage the workload. The pharmacist said that as most of the prescriptions were received electronically and this helped team members to keep on top of the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The dispensing labels were signed by team members to show who had dispensed or checked each item.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And she knew which tasks could and should not be carried out if the responsible pharmacist (RP) was not in the pharmacy. The till would not allow sales of medicines until a pharmacist had signed in.

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 at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed and the RP record was largely completed correctly. But there had been a few occasions recently where the RP had not signed in and some occasions where they had not signed out when they had finished their shift. The pharmacist said that he would ensure that the record was completed correctly in future. And he would remind the other pharmacists to also complete the record. The private prescription records were mostly completed correctly, but the prescriber's details and date on the prescription were not always recorded correctly. This could make it harder for the pharmacy to find these details if there was a future query. 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 he would ensure that all the relevant information was recorded for private prescriptions and emergency supplies in future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used his own smartcard to access the NHS electronic services. Bagged items waiting collection could not be viewed by people in the shop area. Team members had completed training about data protection.

The complaints procedure was available for team members to follow if needed and details about it were displayed at the medicines counter. The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried any out between 2020 to 2022.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. He said that there had not been any recent safeguarding concerns at the pharmacy. And he was in the process of updating the pharmacy's contact details for the local safeguarding agencies, so that team members could readily access this information.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely, and they do the right training for their role. They are provided with some ongoing training, but this is not structured. Team members can discuss any concerns that they have and make suggestions to help improve the pharmacy's services.

Inspector's evidence

There was one pharmacist (pharmacy owner) and one MCA working during the inspection. The MCA had completed an accredited course for her role. The pharmacist explained that the pharmacy was in the process of recruiting a dispenser. The current team were managing the workload well. The pharmacist and MCA communicated effectively to ensure that people were provided with their medicines promptly.

The MCA appeared confident when speaking with people and she asked suitable questions to establish where a medicine was suitable for a person. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. But she was not aware of the restrictions on sales of pseudoephedrine-containing products. The pharmacist reminded her that there was an alert on the wall about the sale of medicines containing pseudoephedrine. And there was also a list of higher-risk over-the-counter medicines displayed next to the medicines counter.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He said that he had completed some training about skin conditions recently. And he was planning to undertake the face-to-face training for the flu vaccination service. The pharmacist felt able to make professional decisions.

Team members were not provided with ongoing training on a regular basis, but they did receive some. The MCA said that the pharmacist passed on important information to her. She explained that she was planning to do more structured training again, but it had been put on hold due to the increased workload during the pandemic.

The MCA said that she had ongoing informal performance reviews and appraisals with the pharmacist, but these were not formally documented. She had a good working relationship with the pharmacist and felt that she could discuss any issues with him at any time. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure, and clean environment for its 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 pharmacist could hear conversations at the counter from where he checked medicines and he could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned at a suitable distance from each other which helped people to socially distance while waiting for their medicines. A clear screen at the medicines counter was used to help minimise the spread of infection. 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 located at the rear of the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Some people’s personal information on bagged items waiting collection could potentially be read by people accessing the consultation room. The pharmacist explained that the consultation room was rarely used and he would remain with people at all times. He said that he could usually have private conversations with people without having to use the consultation room, as there was usually only one person in the shop area. The pharmacist said that he had considered installing a blind to cover the bagged medicines. And he would address this issue as soon as possible.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy's services and opening times were clearly advertised. There was a small step up to the pharmacy. The MCA said that people using a wheelchair or walking aids were able to easily access the pharmacy. There was a clear view of the main entrance from the medicines counter and she said that she would help people if they needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept at the pharmacy. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that prescriptions for higher-risk medicines were usually highlighted. So that he had the opportunity to speak with these people when he handed them their medicines. The pharmacist said that the pharmacy supplied valproate-containing 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 additional warning cards and patient information leaflets were kept with the medicines in a drawer and the pharmacist said that these were supplied to people when needed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that he would ensure that these prescriptions were highlighted in future. The pharmacist said team members checked CDs and fridge items with people when handing them out.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly and this activity was recorded. Items with a short expiry were marked and there were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. The pharmacist confirmed that '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. 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 in future. Uncollected prescriptions were checked monthly and items remaining uncollected after around two months were returned to dispensing stock where possible. And the prescriptions for these items were returned to the NHS electronic system or to the prescriber.

The pharmacist 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 the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy did not request prescriptions for 'when required' medicines. The pharmacist said that people contacted their GP if they needed them when their packs were due. The

pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were not put on the packs to help people and their carers identify the medicines. And 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 pharmacist said that information leaflets were supplied if there was a change to someone's medicines or if they were prescribed a new medicine. He said that he would ensure that these were routinely supplied in future and the backing sheets would be attached.

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.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA via email. The pharmacy kept a record of the actioned alerts for future reference and 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.

Up-to-date reference sources were available in the pharmacy and online. 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. The pharmacy had disposable masks, gloves, and hand sanitiser available for team members to use. And there was hand sanitiser available at the medicines counter for people to use if they wanted to while they were in the pharmacy.

Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridge was 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.