General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Joydens Wood Pharmacy, 2 Birchwood Parade, Woodside Drive, Wilmington Estate, DARTFORD, Kent, DA2 7NJ

Pharmacy reference: 1032690

Type of pharmacy: Community

Date of inspection: 02/10/2019

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. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service and influenza vaccinations. And it supplies medication in multi-compartment compliance packs to several people who live in their own homes to help them manage their medicines.

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

Inspector's evidence

The pharmacy adopted a range of measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood. 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 and reviewed regularly for any patterns. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. A report had been completed, but the medicines were still kept next to each other on the shelf. The second pharmacist said that he planned to highlight shelves where incidents had occurred with medicines to help minimise the chance of a similar mistake.

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 trainee dispenser said that the pharmacy would open if the pharmacist had not turned up. She said that she would accept prescriptions and assemble these in advance of the pharmacist arriving. She knew that she should not any medicines or hand out dispensed items before they had turned up. The inspector reminded her what she could and couldn't do if the pharmacist had not turned up.

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. All necessary information was recorded when a supply of an unlicensed medicine was made. And there was a signed in-date patient group direction available for the influenza vaccination services. The private prescription record was largely completed correctly, but the prescriber's details were not always recorded. 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. Controlled drug (CD) registers examined were mostly filled in correctly, but the address of the supplier was not recorded in the registers. The second pharmacist said that he would ensure that this information was recorded in future. The CD running balances were checked at regular intervals, and the recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was largely completed correctly and the correct RP notice was

clearly displayed. There were a few occasions recently when the RP had not completed the log when their shift had ended. This could make it harder to know who the RP had been if there was a future query.

Patient confidentiality was largely protected. Confidential waste was shredded, 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 smart cards during the inspection. Bagged items waiting collection could be viewed by people using the pharmacy, but prescriptions were facing away from the counter. Not all items in the consultation room were protected properly. Following the inspection, the pharmacist sent the inspector a photo showing that these were now protected.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and over 97% of respondents were satisfied with the pharmacy 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 most of the complaints received were about medications not being ready for collection. He kept an audit trail for each time the pharmacy contacted the surgeries to request prescriptions.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The second 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 trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns. And this means that they can help improve the systems in the pharmacy. 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 regular pharmacist, one locum pharmacist, one trained dispenser, one trainee dispenser and one trained medicines counter assistant (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. And she 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.

One of the trainee dispensers had worked at the pharmacy for around four months and had not yet been registered on an accredited course. The regular pharmacist said that he had planned to enrol her on a course. The inspector received an email the following morning, confirming that the team member had been registered on an accredited dispenser course.

The pharmacists were aware of the continuing professional development (CPD) requirement for the professional revalidation process. And they had submitted their CPD entries. One of the pharmacists had recently completed training about working in a prison and lone working. The regular pharmacist said that he planned to carry out CPD on lithium and valproate medicines as the pharmacy was due to carry out an audit on these medicines.

Team members were provided with ongoing training on a regular basis and training records were kept. The regular pharmacist monitored the training and ensured that all team members had understood each module. Team members received monthly healthy living leaflets and a quiz was used to check their understanding. And they were allowed time to complete these during the working day. The pharmacists had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The regular pharmacist had worked at the pharmacy for around five months. He said that he planned to carry out appraisals and performance reviews for all team members. Team members felt comfortable about discussing any issues or concerns with the pharmacist.

Targets were not set for team members. The regular pharmacist said that he provided the services for the benefit of the people who used the pharmacy and he planned to implement more services such as emergency hormonal contraception.

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. But the pharmacy could do more to keep some areas tidy and free from clutter.

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. 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.

Workspace in the dispensary was limited and there was very little room for dispensing. Most of the work tops were covered with stacks of baskets with medicines in. There were two clear areas used to dispense medicines and check dispensed items. There was only one computer in the dispensary. This was an issue when more than one person needed to use the computer and it caused delays with dispensing if people needed to use the computer. Team members were often disrupted and distracted while dispensing if people needed to use the computer. The pharmacist said that there were plans to install a second computer at the medicines counter so that team members could check people’s medication records without interrupting the dispensers.

Some bags of dispensed medicines were not kept securely. And some people’s personal details were potentially visible on them. The pharmacist said that the bags would be moved or access to them restricted. There were three chairs in the shop area and these had arms to aid standing. They were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. A blind was available to cover the window when needed.

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. The pharmacy gets its medicines from reputable suppliers and mostly stores them properly. It responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. 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

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 was 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. The pharmacist said that he kept a record of blood test results for some people, but not all people taking these medicines. 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 CDs were highlighted but prescriptions for Schedule 4 CDs were not. The MCA was not sure which prescriptions were valid only for 28 days. The pharmacist said that he would ensure that prescriptions for CD medicines were highlighted to help minimise the chance of these being handed out after the prescription had expired. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group taking these medicines. 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 around every three months and this activity was recorded. Stock due to expire within the next few months was marked. There were several out-of-date medicines found with dispensing stock and some medicines were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The dispenser said that she would remind team members to keep medicines in their original packaging and would implement a more reliable date-checking system.

The trainee dispenser said that 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. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. The MCA said that items uncollected after around three months were returned to dispensing stock where possible. And the uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

The pharmacist said that he carried out verbal assessments for the people who requested to have their medicines dispensed into multi-compartment compliance packs. He said that most of them had been referred by their GP. Prescriptions for people receiving their medicines in 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 dispenser said that people contacted the pharmacy when they needed these with their packs. The pharmacy kept a record for each person which included any changes to their medication and they kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets 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 that 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. The pharmacy obtained people's signatures for deliveries where possible. There were multiple people's details on each sheet and the layout made it harder to ensure that other people's details were protected when signatures were recorded. The pharmacist said that he would ensure that other people's personal information was protected when signatures were recorded. 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. Drug alerts and recalls were received from the NHS and the MHRA. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive and it was being used. Team members had been trained on how to use the equipment and written procedures were available.

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. 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.

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