General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M.D.Moore Chemist, 141 Dartford Road, DARTFORD, Kent, DA1 3EN

Pharmacy reference: 1032694

Type of pharmacy: Community

Date of inspection: 27/06/2019

Pharmacy context

The pharmacy is a family run business located on a main road surrounded by residential premises. It is in between two towns. The nearest large town centre is in Dartford about one mile away. The people who use the pharmacy are mainly older people. And it receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, and travel vaccinations (including yellow fever). It uses patient group directions for the supply of anti-malarials and Champix. It carries out health checks, including cholesterol testing, BMI, alcohol screening, smoking screening and blood pressure. The pharmacy provides multi-compartment compliance aids to around 40 people who live in their own homes to help them take their medicines safely. And it provides substance misuse medications to one person.

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 to help provide them safely. It largely protects people's personal information. It regularly seeks feedback from people who use the pharmacy. And it largely keeps 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. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed to indicate that they had read and understood the 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 and reviewed regularly for patterns. Medicines that 'look alike or sound alike' were separated and highlighted. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A copy of the incident report was kept at the pharmacy for future reference. Incidents were reported to the National Pharmacy Association and learnings were shared with other pharmacies. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The pharmacy had supplied the correct medicine and the person did not want to pursue the matter further.

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) said that team members did not have access to the pharmacy if the pharmacist had not turned up. She confirmed that she had contact details for both pharmacists and would attempt to contact them. She knew that she should not sell 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 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 full prescriber details were not always recorded on the private prescription record. A few hospital prescriptions did not have the prescriber's address recorded and one did not have the prescriber's name. The nature of the emergency was not 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 superintendent (SI) pharmacist said that he would contact the software provider to ask if this could be displayed on the log. Signed in-date patient group directions were available.

Controlled drug (CD) running balances were checked around once a month. Liquid CD overage was

recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist record was completed and the correct RP notice was clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own Smartcards during the inspection. Some dispensed items waiting collection were kept behind the medicines counter. Prescriptions were facing the shop area and this meant that people's personal information could potentially be viewed by people using the pharmacy. The MCA turned these around during the inspection so that the information was not visible.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 survey were available on the NHS website. Results were positive with 100% of respondents satisfied with the pharmacy overall. The pharmacy complaints procedure was displayed in the shop area. The pharmacist said that the pharmacy had received a complaint about one of the previous delivery drivers. She had investigated the complaint and apologised to the person.

The pharmacist and SI had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The MCA said that she had not completed any safeguarding training at the pharmacy. But she had completed some in her previous employment. She could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that she was not aware of any safeguarding issues at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy.

Inspector's evidence

There were two pharmacists (one was the SI and the other was his wife), one trainee NVQ level 3 student and one MCA working during the inspection. The team wore smart uniforms with name badges displaying their role. 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 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.

The MCA had recently completed an accredited counter assistant course. She said that she was due to start the health check training so that she could provide this service. The trainee dispenser had already completed the health check course and a counter assistant course. She was enrolled on an accredited pharmacy course and planned to register with the GPhC as a pharmacy technician once this had been completed. The SI printed updates and reports so that team members could read these. They signed to indicate that they had understood them. The SI had completed declarations of competence and consultation skills training for the services offered. Some training certificates were displayed in the consultation room.

The trainee dispenser said that there were meetings held around once a month to discuss any issues. Team members appeared to have a good working relationship with the pharmacists. The MCA said that she felt confident to discuss any issues with the pharmacists. Team members had yearly appraisals and performance reviews. And these were documented.

Targets were not set. The SI said that services were provided for the benefit of people who use 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; this presented a professional image. Pharmacy only medicines were kept behind the counter. The pharmacists had a clear view of the medicines counter from the dispensary. They could listen to conversations and could intervene when needed.

Air-conditioning was not available; the room temperature was suitable for storing medicines on the day of the inspection. The SI said that the room temperature was monitored to make sure that it remained below 25 degrees Celsius. There were two chairs in the shop area for people to use. But these were close to the medicines counter so conversations at the counter may potentially be overheard.

The consultation room was accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area. There were two chairs and a desk available. The room was accessible to wheelchair users. And suitable for the services offered. 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 manages its services well and provides them safely. It gets its medicines from reputable suppliers. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

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.

The pharmacist said that she checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. But a record of results was not kept. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for these medicines were highlighted so there was potential for the pharmacist to speak with these people when they collected their medicines. The pharmacist said that prescriptions for schedule 3 and 4 CDs were highlighted. There were none available to check during the inspection. Prescriptions were not generally kept with items until the medicines were collected. This could increase the chance of medicines being supplied when the prescription was no longer valid. The pharmacist said CDs and fridge items were checked with people when handing them out. She confirmed that all people in the at-risk group who were taking valproate medicines were provided with warning cards and patient information leaflets. The pharmacist said that the pharmacy supplied valproate medicines to a few patients. There were currently two people in the at-risk group who needed to be on the Pregnancy Prevention Programme. Their medication records were annotated with this information.

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. There were no date-expired items found in with dispensing stock. And medicines were kept in suitably labelled packaging.

The pharmacist 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 medicines were dispensed. The pharmacist said that uncollected prescriptions were checked every two weeks. She confirmed that items uncollected after around three months were returned to dispensing stock where possible. People were sent a text reminder when their medicines were ready for collection. The pharmacy kept a record of all prescriptions collected.

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 by the pharmacy; the dispenser said that the pharmacy contacted people to ask if they needed them. The pharmacy kept a record for each person

which included any changes to their medication. Compliance aids were suitably labelled, but there was no audit trail to show who had dispensed and checked each compliance aid. This could make it harder for the pharmacy to identify who had done these tasks, and limit the opportunities to learn from any mistakes. Medication descriptions were put on the compliance aids. Patient information leaflets (PILs) were not routinely supplied. This could make it harder for people have up-to-date information about how to take their medicines safely. The pharmacist said that she would ensure that these were supplied in 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 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 using an application on a mobile phone. These were recorded in a way so that other people's information was protected. The pharmacy had a list of people's medicines which were out for delivery so that people could be informed if they contacted the pharmacy. Failed deliveries were returned to the pharmacy before the end of the working day. A card was left at the address instructing the person to contact the pharmacy to rearrange delivery.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the MHRA via ePharmalerts. 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 for the implementation of the EU Falsified Medicines Directive. Team members had received some training. And the equipment was in use.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy 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 separate measure was marked for CD use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

The blood pressure monitor was calibrated every two years. The cholesterol machine was checked daily and calibrated every two weeks. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. And 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.