General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 2 The Row, New Ash Green, DARTFORD, Kent, DA3 8JB

Pharmacy reference: 1032703

Type of pharmacy: Community

Date of inspection: 17/05/2019

Pharmacy context

The pharmacy is in a shopping centre in a large village near to Gravesend. It is part of a larger chain owned by Paydens. The people who use the pharmacy are mainly older people and families. The pharmacy provides a range of services, including Medicines Use Reviews (MUR), the New Medicine Service (NMS), multi-compartment compliance aids and substance misuse medications.

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 keeps the records required by law, but they are not always complete. So, they may be less reliable in the event of a future query. The pharmacy generally protects people's personal information. It actively seeks feedback from the public. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some 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. Near misses were highlighted with the team member involved at the time of the incident; they sometimes identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for trends and patterns. 'Sound alike and look alike' medicines were marked and items in similar packaging were kept separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong bag of items had been given to a person. The pharmacist said that team members were reminded to check the address provided against the bag label and prescription before handing out. The medicines had not been taken and were returned to the pharmacy.

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. A stamp was used on prescriptions to ensure that the dispenser accuracy checker could clearly identify which prescriptions she could check.

Team members' roles and responsibilities were specified in the SOPs. One of the dispensers thought that she could carry out some dispensing tasks before the pharmacist had turned up. Another dispenser corrected her and said that this was not allowed. The medicines counter assistant (MCA) knew that she should not sell any medicines or hand out bagged items if the pharmacist had not turned up.

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. The full prescriber details were not routinely recorded in the private prescription record. All necessary information was recorded when a supply of an unlicensed special was made.

Signed in-date patient group directions were available for the services offered. The emergency supply record was completed correctly. Controlled drug (CD) running balances were checked around once a month. The address of the supplier was not routinely recorded in the CD register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) 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. Smart cards 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 not be viewed by people using the pharmacy. But the prescriptions for these items were kept on the medicines counter. The MCA moved these under the counter during the inspection. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results were available in the shop area. The most recent results available on the NHS website were from the 2017 to 2018 survey. Over 92% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to refer to where needed. The pharmacist said that she was not aware of any complaints since she started working there around one year ago.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed training provided by the pharmacy. The dispenser 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 dispenser said that there had been a concern about how a person was speaking with a vulnerable person in the pharmacy. The person’s case worker was informed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. The team members discuss adverse incidents and use these to learn and improve. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. And they can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular full-time pharmacist, one dispenser accuracy checker, three dispensers, one trainee dispenser and two MCAs 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. 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 trainee dispenser had been enrolled on an accredited pharmacy course. Team members completed regular online training. The pharmacist said that this was monitored by the area manager. Each team member had a folder containing certificates for training completed. The pharmacist had completed consultation skills training and declarations of competence for the services.

The pharmacist said that the pharmacy was in the process of implementing regular team meetings. The dispensers said that they felt confident to raise any issues during the working day. The accuracy checking dispenser said that she had mentioned about needing a raised checking bench and a padded floor area. These had been provided and she said that these had helped with her posture.

The pharmacist said that targets were not set. She said that a pharmacist came twice a month to assist with carrying out Medicines Use Reviews. The pharmacist said that she did not feel under pressure and carried out the services for the benefit of the people using the pharmacy.

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. Pharmacy only medicines were kept behind the counter. The pharmacy was bright, clean and tidy throughout; this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines.

There were seven 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 door was not kept locked when not in use. Low-level conversations in the consultation room could not be heard from the shop area. The room was suitable for the services offered. The window in the door was covered with a blind. There were two chairs and a small desk available. The room was accessible to wheelchair users. People's personal information was kept securely. Two sharps bins were placed on high shelves and one next to the sink at the rear of the room. There was a yellow bag containing clinical waste on the floor at the back of the room.

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. But it does not always highlight when high-risk medicines are dispensed, which may mean that people are not given all the information that they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The dispenser said that some people called the pharmacy before they arrived, and these people were assisted at the rear door which was easier for them to get to. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that she did not routinely check monitoring record books for people taking higher risk medicines. And 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 not highlighted so there is a risk that the opportunity to speak with these people is missed. Prescriptions for schedule 3 CDs were highlighted. But prescriptions for schedule 4 CDs were not highlighted and the trainee dispenser thought that these prescriptions were valid for six months. This could increase the chance of these medicines being supplied when the prescription has expired. The dispenser said that fridge and CD items were sometimes shown to people when handing out. She confirmed that the pharmacy supplied valproate medicines to a few patients who may become pregnant. But it did not have the warning cards available. She said that these had been provided to people when they were initially supplied with their medicines. And she would order some more from the supplier.

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 a few date-expired items found in with dispensing stock. One item had expired in March 2018. The dispenser said that the stock takers had recently been in and they had also missed it. This could increase the chance of expired medicines being supplied.

Part-dispensed prescriptions were checked frequently. ‘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 items were collected. Uncollected prescriptions were checked monthly. Items uncollected after around three months were returned to dispensing stock where possible. Prescriptions were returned to the prescribers and a record was kept at the pharmacy.

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 dispenser said that people routinely contacted the pharmacy when 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.

Compliance aids were suitably labelled and there was an audit trail to show who had dispensed and checked each compliance aid. Medication descriptions were put on the compliance aids. Patient information leaflets (PILs) were routinely supplied. The medicines were checked by a second person before being dispensed into the compliance aids.

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. The pharmacy obtained people's signatures for deliveries where possible; these were recorded in a way so that another person's information was protected. The dispenser said that all deliveries were within the local area.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from head office. Any action taken was recorded and kept for future reference.

The pharmacy was using the equipment for the EU Falsified Medicines Directive. The dispenser explained querying with the suppliers when warnings appeared on the screen. An SOP was available and team members had signed to indicate that this had been read and understood.

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. Separate measures were 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 pharmacist said that the blood pressure monitor was due to be replaced. And that a sticker would be put on the machine to indicate when it should be replaced. The weighing scales were in good working order. 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 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.