General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ormay Chemist, 224 Bexley Road, ERITH, Kent, DA8 3HD

Pharmacy reference: 1032735

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

The pharmacy is located on a busy high street and it is surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 85% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, influenza vaccinations and used private Patient Group Directions for the supply of antimalarials and medicine for erectile dysfunction. It supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. The pharmacist had recently updated the pharmacy's standard operating procedures (SOPs) and team members were in the process of reading them and signing to show that they had understood them. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. But near misses were not recorded. A near miss log was printed during the inspection. The pharmacist said that he would ensure that this was used and reviewed regularly for patterns in the future. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person's doctor had realised the error and the person had taken some of the medicines. A dispensing incident report had been completed and the incident had been reported on the National Reporting and Learning System. The shelf edges where these medicines were kept now highlighted to help prevent a recurrence.

There was limited workspace in the dispensary. but it was kept 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 pharmacist said that team members would have access to the pharmacy if pharmacist had not turned up, but he said that the pharmacy would not open until the pharmacist had arrived. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out any dispensed items if the pharmacist was not in the pharmacy. The dispenser did not know that dispensing tasks should not be carried out if there was no responsible pharmacist signed in. She said that she had never experienced that situation. The pharmacist confirmed that he would ensure that all team members were made aware of tasks which needed a responsible pharmacist to be signed in before they could be carried out.

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. The responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made. And there were signed in-date Patient Group Directions available for the relevant services

offered. The private prescription records were completed correctly. But, there were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that he would ensure that all the required information was on them in future before making supplies. 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 the nature of emergency was recorded in the future. Controlled drug (CD) registers examined were filled in correctly and liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacy technician's smartcard was being used when she was not at work. The pharmacist said that he would apply for smartcards for all dispensary team members so that these were not shared. The pharmacist used his own smartcard to access the NHS electronic services. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and results from the 2017 to 2018 survey were available on the NHS website. Results were positive overall and over 99% 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 he was not aware of any complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training level 3 about protecting vulnerable people. The trainee MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. The pharmacist gave an example of action he had taken in response to a safeguarding concern. 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. The team members can take professional decisions and they can raise any concerns. They are provided with ongoing training to support their learning needs and maintain their knowledge.

Inspector's evidence

There was one pharmacist (who was the superintendent pharmacist), one trained dispenser, one trainee dispenser and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms. And they worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee 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.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He explained that he had recently completed some training about vaccinations and travel advice for people planning to travel to the Middle East. He said that there were a few people who asked for information about the requirements after he had completed the training. Team members received monthly information leaflets about seasonal topics and these were provided by an external organisation. The pharmacist explained that he checked that these had been completed and discussed the answers with team members. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And targets were not set for team members. The pharmacist said that team members had ongoing informal appraisals and performance reviews, but these were not documented. He felt able to take any professional decisions.

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.

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.

There was one chair in the shop area and it was in front of the medicines counter. The MCA said that she would offer the use of the consultation room if someone wanted to discuss something in a more private setting. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area.

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 stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. 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.

The pharmacist said that he did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. 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 prescriptions for higher-risk medicines and Schedule 3 and 4 CDs would be highlighted in the future. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on a Pregnancy Prevention Programme. The pharmacy did not have the relevant patient information leaflets or warning cards available. The pharmacist said that he would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. A full check of the expiry dates had not been carried out for around one year and short-dated items were not marked. But, there were no date-expired items found in with dispensing stock. The pharmacist said that he would implement a more reliable expiry-date checking routine so that items could be removed at the start of the month they were due to expire. This would help minimise the chance of out-of-date medicines being supplied to people.

The pharmacist said that part-dispensed prescriptions were checked frequently. '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. The trainee MCA said that uncollected prescriptions were checked frequently and items uncollected after around three months were returned to dispensing stock where possible. She explained that the person's medication record would be updated and a note made so that the person could be informed if they came to collect their medicine. The pharmacist said that uncollected prescriptions were returned to the NHS electronic system or disposed of appropriately in the pharmacy.

The pharmacist said that he referred people to their GP for an assessment 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. Prescriptions for 'when required' medicines were not routinely requested; the pharmacist said that people contacted the pharmacy 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 and there was an audit trail to show who had dispensed and checked each pack. But, the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were 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 he would ensure that the information leaflets were supplied each month and the backing sheets were attached to the packs.

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 so the layout makes it harder to ensure that 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 but it was not yet being used. The pharmacist said that team members had not yet done the training. He said that the pharmacy planned to use the equipment fully in the near future.

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 and separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Gloves were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for around 18 months. He said that this would be replaced in line with the manufacturer's guidance. The shredder was 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 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.