General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mistvale Chemist, 127 Canterbury Road, FOLKESTONE, Kent, CT19 5NR

Pharmacy reference: 1032750

Type of pharmacy: Community

Date of inspection: 29/10/2019

Pharmacy context

The pharmacy is located on a busy main road near to a town centre in a largely residential area. 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, influenza vaccinations and a stop smoking service. It supplies medications in multi-compartment compliance packs to some 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

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

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 mostly 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. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting processes. 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 but these were not routinely reviewed for any patterns. And this may mean that opportunities to identify improvements may be missed. 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 quantity of medicine had been supplied to a person. The pharmacy had reported the incident to the pharmacy's head office and recorded it on the National Reporting and Learning System. Team members were reminded to highlight any dosage changes on prescriptions so that this may help them to identify these changes during the dispensing and checking processes.

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.

The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. But, she knew that she should not sell any medicines or hand out any dispensed items until the pharmacist was in the pharmacy. The dispenser said that she would carry out dispensing tasks before the pharmacist had turned up. The inspector reminded her what she could and shouldn't do if there was no responsible pharmacist (RP) signed in. The pharmacy's SOPs stated that team members could dispense items before there was a RP. The pharmacist said that he would speak with the superintendent pharmacist to ensure that the SOPs were changed.

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 private prescription record and emergency supply record were completed correctly. And all necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the suppliers was not recorded. The pharmacist said that he would ensure this was recorded in the future. The CD running balances were checked at regular intervals and at the time of supply or receipt. 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. The right RP notice was clearly displayed and the responsible

pharmacist (RP) log was completed correctly.

Confidential waste was removed by a specialist waste contractor, 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 smartcards during the inspection. 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 survey were available on the NHS website. Results were positive and 98% 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 there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had been provided with some safeguarding training by the pharmacy. The 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 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 can raise any concerns or make suggestions. The team members can take professional decisions and team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist, one trained dispenser, one trainee dispenser and one trained MCA working during the inspection. Most team members had completed an accredited course for their role and the other was undertaking training. The team members 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 pharmacy was in the process of recruiting a dispenser and an MCA.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some updates about product information and other pharmacy related topics. He was aware of the continuing professional development requirement for the professional revalidation process. And he had recently completed some training provided by the CPPE about sepsis. The pharmacist 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. But the pharmacy did not have any regular meetings. The pharmacist said that team members had informal appraisals and performance reviews, but these were not documented. He said that he tried to let the local surgeries know about any medicine supply issues so that the prescribers might be able to consider alternate medicines. He said that this had helped to minimise the number of times people had to wait for a different medicine to be prescribed.

Targets were not set for team members. The pharmacist said that services were provided for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. 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. 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 not available, but the pharmacist said that the room temperature during the warmer months was suitable for storing medicines. The dispensary was somewhat cluttered and there were baskets piled high on the dispensary worktops. There were several baskets containing medicines kept on the floor in the dispensary and other bagged items waiting collection. The pharmacist said that he would ensure that these were moved and workspaces kept clearer.

There was one chair in the shop area for people to use while they were waiting for their medicines. The MCA said that a person using the pharmacy had mentioned that the pharmacy may benefit from additional seating. She said that she would take a chair from the consultation room if needed. And she would offer the use of the consultation room to people who wanted to discuss anything in a more private setting.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept safeguarded from unauthorised access when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were generally clean and not used for storing pharmacy items. There were separate hand washing facilities available. The bath in the toilet area was not clean. But this was not used. The pharmacist said that he would ensure that it was cleaned.

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 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. 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 always highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The MCA knew that prescriptions for Schedule 3 CDs were only valid for 28 days, but she was not sure how long prescriptions for Schedule 4 CDs were valid for. There were some expired prescriptions for CDs found waiting collection. The dispenser said that she would ensure that these were highlighted. 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. Most of the packs for this medicine had the warning cards attached but some did not. The pharmacy did not have additional patient information leaflets or warning cards available. The pharmacist said that he would order replacements from the suppliers.

Stock was largely stored in an organised manner in the dispensary. The dispenser said that expiry dates were checked every six months. Stock due to expire within the next six months was generally marked. Several medicines were found which were not kept in their original packaging. And some of the foil strips did not include all the required information on the container such as batch numbers or expiry dates. There were several mixed batches found with dispensing stock. 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 pharmacist said that he would ensure that medicines were kept in their original packaging.

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. The dispenser said that uncollected prescriptions were checked at regular intervals and they were kept until the prescription had expired. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the

items were returned to dispensing stock where possible.

The pharmacist said that assessments were carried out by people's GPs to show that they needed their medicines to be in multi-compartment compliance packs. He said that if someone requested to have their medicines in packs, he referred them to their GP. Prescriptions for people receiving their medicines in multi-compartment compliance 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 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. The pharmacist said that he would ensure that these were attached in the future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The packs were assembled in the consultation room. The dispenser said that if the room needed to be used for a consultation while they were assembling the packs, they had to clear the desk before finishing assembling them. The pharmacist said that this would be done in a room upstairs in the future so that distractions and interruptions were minimised.

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 might make 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 in the future. 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 installed yet. The pharmacist said that the pharmacy was due to have a different computer system installed within the next few months and then the pharmacy would start using the equipment.

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. Separate liquid measures were marked for CD use only. An electronic tablet counter was available, but there was a layer of powder residue throughout. The pharmacist said that he would ensure that this was either cleaned or not used in the future. A triangle tablet counters was marked for cytotoxic use only. This helped to avoid any cross-contamination.

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 over two years. He confirmed that he would arrange for this to be calibrated or replaced. The carbon monoxide testing machine was calibrated by an outside agency. 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 for the larger fridge but only the current temperature was checked for the smaller fridge. The MCA had been recording the current temperature of the smaller fridge but was not aware how to check the maximum or minimum temperature or what the recommended range was. The current temperature for the smaller fridge was 5.2 degrees Celsius. The inspector showed the MCA how to check the temperatures properly and how to reset the thermometer. Records indicated that the temperatures for the larger fridge were within the recommended range. The fridges were suitable for storing medicines and were 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.