General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J. Spensley, 1 Twydall Green, GILLINGHAM, Kent, ME8 6JX

Pharmacy reference: 1032781

Type of pharmacy: Community

Date of inspection: 03/03/2020

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, free condoms and it provides medicines as part of the Community Pharmacist Consultation Service. It uses patient group directions (PGD) to supply influenza vaccinations, smoking cessation medicines, chlamydia treatment, emergency hormonal contraception. It also It supplies medications in multi-compartment compliance packs to some 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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. And this information is regularly shared throughout the company.
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 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 uses this information to help make its services safer and reduce any future risk. And it shares this information with other pharmacies within the company. Team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information and it regularly seeks feedback from people who use the pharmacy. And largely keeps the records it needs to by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted 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 and review processes. Team members had signed to show that they had read and understood the SOPs and they appeared to be following them during the inspection. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. A different medicine had been placed between different strengths of omeprazole to help minimise the chance of the wrong medicine being selected again following a near miss. Dispensing incidents where the product had been supplied to a person 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. An apology was made to the person and the correct medicine was supplied. A 'look alike or sound alike' (LASA) sticker had been placed on the shelf where the medicines were kept.

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. The accuracy checking technician (ACT) knew which prescriptions she could check. She that she would only check ones which had been stamped by the pharmacist and only if she had not dispensed the items.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not arrived in the morning. She knew that she should not sell any medicines or hand out dispensed items until the pharmacist had arrived. She said that she would accept prescriptions and inform the person that they would have to return later to collect their medicines. The ACT knew that she should not carry out any dispensing tasks if there was no responsible pharmacist (RP).

The pharmacy had current professional indemnity and public liability insurance. 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 filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock

available. The RP log was completed correctly the right RP notice was clearly displayed. The private prescription records were largely completed correctly, but the prescriber's details were not routinely recorded. This could make it harder for the pharmacy to find these details if there was a future query. 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 RP said that she would remind team members to include all relevant information in the private prescription and emergency supply records in the future.

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 smartcards during the inspection. Bagged items waiting collection could be viewed by people using the pharmacy, but people's personal information was not facing the medicines counter. The pharmacy team members had completed training about the General Data Protection Regulation (GDPR).

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Over 92% of respondents thought that the pharmacy was very good at providing an efficient service. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The RP said that there had not been any recent complaints.

The pharmacists and pharmacy technicians had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some of the other team members had undertaken safeguarding training provided by the pharmacy. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The RP 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 do the right training for their roles. And they are provided with ongoing training to support their learning needs and maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. And the team discusses adverse incidents and uses these to learn and improve.

Inspector's evidence

There were two pharmacists, one ACT, one pharmacy technician, one trainee dispenser and one trained MCA working during the inspection. One of the dispensers was currently on planned leave. Most team members had completed an accredited course for their role and the rest were undertaking training. The RP said that one of the trainee MCAs had recently been enrolled on an accredited course, and the trainee dispenser would be enrolled on a suitable course towards the end of her probation. They 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 had worked at the pharmacy for over 15 years and was confident when speaking with people. She used effective questioning techniques to establish whether the medicines were suitable for the person. She was aware of the restrictions on sales of pseudoephedrine containing products and knew the reason for this. 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.

The pharmacists and pharmacy technicians were aware of the continuing professional development requirement for the professional revalidation process. The pharmacy technician said that she had recently completed training about the GDPR, sepsis and risk management. Team members had access to online training modules provided by the pharmacy's head office. The pharmacy technician said that she usually access the online training modules at home, but some of the other team members did their training in the pharmacy during their lunch breaks. The RP said that she ensured that team members completed any mandatory training. And team members kept certificates for any training they had completed. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The RP said that she felt able to take professional decisions. She had had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacy received a monthly newsletter from the pharmacy's head office. This included information about patient safety. And a recent one had listed the top five medicines which had been involved in dispensing incidents and near misses. It also included information about LASA medicines and had a colour photo of the medicines next to each other to show how similar the packaging was. Team members signed to show that they had read and understood the information in the newsletter.

The pharmacy technician said that she was expecting an appraisals and performance review to be carried out in the near future. The RP said that she had been the pharmacy manager for around a year and she was in the process of organising them for the qualified team members. She said that she had been carrying out regular reviews with trainees. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy technician said that information

was passed on informally throughout the day, but there were no formalised meetings.

Targets were set for Medicines Use Reviews (MUR) and the New Medicine Service. The RP said that the pharmacy regularly met the MUR target and she would not let her professional judgement be affected. She said that having a second pharmacist working twice a week at the pharmacy helped them to meet the targets.

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 not available; the room temperature on the day of the inspection was suitable for storing medicines. The RP said that a portable air-conditioning unit was available, but this was noisy and it was difficult for team members to hear people in the shop area and it affected their concentration.

There were three 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 to wheelchair users and was located in the shop area. It was suitably equipped and well-screened, but it was not kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet and hand washing facilities were clean and not used for storing pharmacy items. The pharmacy had recently had a kitchen and staff area built to the back of the dispensary. This was kept clean and tidy.

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. The pharmacy dispenses medicines into multi-compartment compliance packs safely. But it 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 were two steps up to the pharmacy with a hand rail available. A door bell was available at a suitable height for people who used a wheelchair. 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 Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The RP said they checked CDs and fridge items with people when handing them out. The RP 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 the Pregnancy Prevention Programme. She said that she had spoken with people taking the medicine or their representative and discussed the risks with them. The pharmacy had the updated relevant patient information leaflets and warning cards available. The RP said that she highlighted prescriptions for higher-risk medicines if she needed to speak with the person. But she did not routinely highlight all prescriptions for these medicines. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. And opportunities to speak with these people when they collected their medicines might be missed.

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 few months were marked. But there were several date-expired medicines found dispensing stock. Medicines were largely kept in their original packaging. The RP said that she would ensure that a more reliable date-checking routine was implemented to help minimise the chance of out-of-date medicines being supplied to people.

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 RP said that medicines could sometimes be sourced from other pharmacies within the organisation and this was co-ordinated by the pharmacy's head office. The MCA said that uncollected prescriptions were checked frequently and items remaining uncollected after around three months were returned to dispensing stock where possible. The RP said that uncollected prescriptions were returned to the NHS electronic system or to the prescriber. And the person's medication record was updated.

The RP said that she carried out assessments for people who had their medicines in multi-compartment

compliance packs to show that they needed them. The pharmacy did not routinely order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs. The pharmacy technician said that the pharmacy managed a few people's prescriptions if they were not able to order for themselves. 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. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. The pharmacy technician said that there were several members of the team who could manage the packs and the workload was shared.

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 and these were recorded in a way so that another person's information was protected. 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. The RP said that team members had undertaken training on how the system worked 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 liquids was available. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle. Tweezers 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 RP said that the blood pressure monitor had been in use for less than one year and the pharmacy received replacement monitors from the pharmacy's head office when needed. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were 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.