General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Spires Pharmacy, Unit 4; The Spires Centre, Deringwood Drive, Otham, MAIDSTONE, Kent, ME15 8XW

Pharmacy reference: 1032828

Type of pharmacy: Community

Date of inspection: 22/05/2019

Pharmacy context

The pharmacy is located on a small parade of shops in a residential area. It is one of two independent pharmacies owned by the same family. The people who use the pharmacy are mainly older people. The pharmacy received around 80% of prescriptions electronically. The pharmacy provides a range of services including, Medicine Use Reviews (MUR) and New Medicine Service (NMS). It provides multi-compartment compliance packs to a few people who live in their own homes to help them take their medicines safely.

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. The pharmacy largely keeps records required by law. It generally protects people's personal information and actively seeks feedback from the public. 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, near miss and dispensing incident reporting and review processes. The pharmacist said that the pharmacy was in the process of updating the standard operating procedures (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 by the superintendent for trends and patterns. Medicines which looked alike or their names sounded alike were highlighted. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that an incident had been reported to the pharmacy in 2018 where the wrong type of medicine had been supplied to a person. He had investigated the incident, reported it to the National Pharmacy Association (NPA) and the pharmacy head office. The pharmacist said that the NPA shared learnings with other pharmacies.

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. Workspace was cluttered, leaving little clear space for dispensing and checking of medicines. The pharmacist initialled the dispensing label when he dispensed and checked each item to show that he had completed these tasks. He took a break between dispensing and checking medicines. And re-checked all items before these were handed out.

Team members roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) did not have access to the pharmacy if the pharmacist had not turned up. She knew that she should not hand out bagged items or sell pharmacy-only medicines if the pharmacist was not on the premises.

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 private prescription record was completed correctly. But 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. Controlled drug (CD) running balances were checked around once a month. 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 correctly 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. The pharmacist used his own smart card to access the NHS electronic services. He said that he took his smart card away off the premises at the end

of his shift. Bagged items waiting collection could be viewed by people using the pharmacy. Some prescriptions were facing the shop area. The MCA turned these to face away from the shop area during the inspection.

The pharmacist said that the pharmacy carried out yearly patient satisfaction surveys. But the most recent results available on the NHS website were from 2018. These were titled as results from 2016 – 2017 survey but appeared to have been collated in March 2018. The complaints procedure was displayed behind the medicines counter. The pharmacist said that there had been a recent complaint received. But it had been due to a prescriber error. The change in medication had not been noticed due to a changeover of patient medication record systems. The pharmacist said that he informed head office who had attempted to contact the person.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The MCA said that she had not completed any training about protecting vulnerable people. But 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 there had not been any safeguarding concerns at the pharmacy.

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. They are provided with ongoing training to help keep their knowledge and skills up to date. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular pharmacist working at the start of the inspection. The MCA returned from her break around 20 minutes after the start of the inspection. They worked well together and communicated effectively. The pharmacist worked hard to ensure that tasks were prioritised, and the workload was well managed. He took a short break between dispensing and checking medicines.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. 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 he contacted people's GPs if they were attempting to purchase medicines as well as having them prescribed.

The MCA had completed an accredited counter assistant course. The pharmacist said that the pharmacy received regular training booklets from suppliers. But there was no evidence to show what training the MCA had completed recently. She could not provide an explanation of any recent training she had completed. The MCA and pharmacist said that they had a good working relationship. He had worked at the pharmacy for around eight years and the MCA for around 5 years. The MCA said that she felt confident to discuss any issues with the pharmacist as they arose.

The pharmacist said that he had a good working relationship with the superintendent pharmacist and could raise any issues with her. He said that the owner of the pharmacy carried out his appraisal around every three years. The MCA said that the owner visited the pharmacy every month to discuss any issues. She said that the pharmacy was in daily contact with the owner and superintendent pharmacist. She confirmed that she had informal appraisals and performance reviews. But these were not recorded. A communication book was used to pass on messages to other team members. Targets were not set. The pharmacist said that he carried out 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. 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. The pharmacist had a clear view of the medicines counter from the dispensary. He could listen to conversations at the counter and intervene when needed. Air-conditioning was not available. The room temperature was 24 degrees Celsius on the day of the inspection. The pharmacist said that the pharmacy was warm during the summer months. The pharmacist said that he monitored the temperature using a wall thermometer. But the maximum temperature it went to was 27 degrees Celsius. So, he would not know if the temperature went above this. The pharmacist said that he would order a suitable thermometer and monitor the room temperature.

The pharmacy was generally clean. But it had not undergone a refit for many years and this reflected in the layout and fixtures and fittings. There were several boxes and dispensed items on the floor in the dispensary which could potentially present a tripping hazard for team members. There was a small bench in the shop area for people to use while waiting. This was at the medicines counter so conversations at the counter could easily be heard. The chairs in the dispensary and consultation area were worn and stained and one was torn. This detracted from the image of the pharmacy.

The consultation area was accessed via the dispensary. Medicines and dispensed prescriptions were on the way, but the pharmacist said that people were always escorted through the dispensary. People’s personal information was visible in several areas of the dispensary and consultation area. Low-level conversations in the consultation area could not be heard from the shop area but these could be heard in the dispensary as there was no door to the area. This could mean that people's privacy may be less well protected. The area was not accessible to wheelchair users. There were several boxes piled high in the consultation area and one fell on the inspector during the inspection. The pharmacist said that he would clear some clutter from the consultation area. Following the inspection, the pharmacist sent a photograph of the areas showing that people’s personal information was not on view.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.There had been a leak through the ceiling in the dispensary. And some of the ceiling tiles had been damaged. The pharmacist said that this had been reported and was due to be fixed.

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. It gets its medicines from reputable suppliers. And 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 a small step into 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. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And he recorded results on the patient's medical record. The pharmacist said that he checked all prescriptions before handing out. And he generally handed items to people so that he could talk with them about their medicines. Prescriptions for schedule 3 and 4 CDs were highlighted. The pharmacist said they checked CDs and fridge items with people when handing them out. He said that all patients taking valproate medicines were provided with warning cards and patient information leaflets when needed. There were currently a few people who needed to be on the Pregnancy Prevention Programme. And he checked that they had the warning card. The pharmacy had patient information leaflets and warning cards available.

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 three months was marked. Lists were kept of items due to expired before the end of July 2019. Items were removed from dispensing stock one month before they were due to expire. And these were disposed of appropriately. There were no date-expired items found in with dispensing stock. Medicines were kept in suitably labelled packaging. Fridge temperatures were checked daily; maxiimum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. But the ice compartment was compacted with ice and the fridge needed defrosting. This could make it harder for the pharmacy to ensure that medicines can be kept at the right temperature in the future. Following the inspection, the pharmacist confirmed that the fridge had been defrosted and that he would order a new thermometer.

The pharmacist said that 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. Uncollected prescriptions were checked monthly. Items uncollected after around three months were returned to dispensing stock where possible. The pharmacist said that prescriptions were returned to the prescriber or to the NHS spine. He confirmed that he routinely contacted people to remind them about their medicines waiting collection. The patient's medication record was updated to show when medicines were not collected. And the pharmacy kept a record of prescriptions returned to the prescriber. So, the person could be informed if they went to the pharmacy.

The pharmacist said that prescriptions for people receiving their medicines in compliance packs were

ordered in advance so that any issues could be addressed before they needed their medicines. He said that prescriptions for 'when required' medicines were not routinely requested; the pharmacist said that people contacted the pharmacy when they needed these medicines. The pharmacist was in the process of keeping records for each patient which would include any changes to their medication. There were some packs which had been prepared but not labelled. The prescriptions were in the dispensary but not with the trays. This could increase the chance of packs becoming mixed up. The pharmacist said that he attached dispensing labels to the backing sheets. Patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements. 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 the MCA. 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 pharmacist said that all deliveries were within the local area. And these were to housebound patients when needed.

Only licensed wholesalers were used for the supply of 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. The pharmacy did not have the equipment for the implementation of the EU Falsified Medicines Directive. The pharmacist was not sure if the equipment had been ordered. He said that he would speak with the superintendent pharmacist.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

The pharmacist said that the blood pressure monitor had been in use for less than one week. The weighing scales were in good working order. The pharmacist said that these were calibrated and replaced by an external organisation. The phone in the dispensary had a long lead and could be taken to a more private area where needed. The shredder was in good working order.

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.