General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Baxters Pharmacy, 164 Canterbury Road, Garlinge, MARGATE, Kent, CT9 5JW

Pharmacy reference: 1032853

Type of pharmacy: Community

Date of inspection: 02/07/2024

Pharmacy context

The pharmacy is on a small parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, a stop smoking service, blood pressure checks, emergency contraception using a patient group direction and flu and COVID vaccinations. The pharmacy runs an INR clinic and supplies medicines against NHS prescriptions as part of this service. And it provides the Hypertension Case Finding Advanced service. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. And it also supplies medicines to a large number of care homes.

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 future risk.
2. Staff	Good practice	2.2	Good practice	Team members are given time set aside to undertake regular and structured training. This helps them keep their knowledge and skills up to date.
		2.5	Good practice	The pharmacy team members are encouraged to provide feedback and raise concerns.
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 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 future risk. People can feedback about the pharmacy's services. And team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information. And it largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. Team members' roles and responsibilities were specified in the SOPs. The admin manager said that the pharmacy would inform its head office if the pharmacist had not turned up in the morning. She said that the pharmacy's head office would make her aware of any staffing issues prior to the pharmacy opening in the morning so that the team could make people aware. One of the dispensers was unclear about some of the tasks that they shouldn't undertake if no responsible pharmacist (RP) attended the pharmacy. But they knew what they should and shouldn't do if the RP was signed in but absent from the premises. The inspector reminded them what they could and couldn't do if the RP had not turned up.

Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. And the pharmacy's head office would be informed. The admin manager said that she was not aware of any recent dispensing errors. Near misses, where a dispensing mistake was identified and corrected before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. The outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. The admin manager said that there had been a few mistakes with atenolol and allopurinol due to similar looking packaging. These had been separated to help minimise the chance of a similar mistake occurring.

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. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and 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 private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder to deal with future queries. 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 at a later

date why the medicine was supplied. The admin manager said that she would ensure that the private prescription record and emergency supply record were completed fully in future.

Team members had completed training about protecting information. Confidential waste was removed by a specialist waste contractor. Computers containing patient information were password protected and 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. However, patient identifiable information on some bagged items waiting collection could potentially be read by people in the shop area. The way these were stored was changed during the inspection so that the information was not visible from the shop area.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The admin manager said that there had not been any recent complaints. She said that the pharmacy's head office would inform her of any complaints. She would investigate the complaint and provide a response.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The admin manager could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She confirmed that there had not been any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. Team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and nine trained dispensers working on the day of the inspection. The admin manager said that a second pharmacist worked one day a week when the pharmacy was providing the INR clinic. Two of the dispensers mostly worked on the medicines counter but could help in the dispensary if needed. The admin manager explained that the team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. There were contingency arrangements for pharmacist cover if needed. Team members appeared to work well together to ensure that tasks were prioritised, and the pharmacy was up to date its workload. The admin manager said that there were a few team members who were being trained to be accuracy checkers. This would help the pharmacy manage its workload better.

Team members appeared confident when speaking with people. One team member, when asked, 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. And team members were observed asking relevant questions before selling over-the-counter medicines to establish whether the medicines were suitable for the person they were intended for.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had recently completed the updated flu training. Team members received regular online training from the pharmacy's head office. Recent training topics completed included; sepsis awareness, fire safety, manual handling, domestic violence and Dementia Friends. The admin manager monitored training and team members were given regular protected time to complete training at work.

There were daily informal huddles and team meetings held every two weeks. The admin manager explained that tasks were allocated during the huddles and team members discussed any issues and the pharmacy's targets. The admin manager regularly attended the pharmacy's head office for management training and meetings. And the pharmacist and admin manager attended a separate managers meeting at head office every three months. The RP felt able to make professional decisions. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members had yearly performance reviews carried out. Team members said they felt comfortable about discussing any issues with the admin manager or pharmacist or making any suggestions. They could go directly to the pharmacy's head office if they had any concerns. A dispenser had suggested

changing how the medicines administration records for care homes were grouped. The suggested change had been implemented and this had enabled the dispenser to manage them better.

Targets were set for the New Medicine Service, the Pharmacy First service and the Hypertension Case Finding Advanced service. The admin manager said that the pharmacy usually met its targets for these services. Team members said that there was a certain amount of pressure to achieve the targets, but they would not let it affect their professional judgement. And that the pharmacy provided these services for the benefit of the people using them.

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 against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. 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. Pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperatures were suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

There was seating in the shop area for people while waiting for services. The consultation room was accessible to wheelchair users, and it could be accessed from the shop area and the dispensary. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. The pharmacy highlights prescriptions for higher-risk medicines so there is an opportunity to speak with people when they collect these medicines. And people who get their medicines in multi-compartment compliance packs receive information they need to take their medicines safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. And 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.

Inspector's evidence

There was step-free access into 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 induction hearing loop appeared to be in good working order. And the pharmacy could produce large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 3 and 4 CDs were marked. This helped minimise the chance of these medicines being supplied when the prescription was no longer valid. The admin manager said team members routinely checked CDs and fridge items with people when handing them out. 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. Team members were aware of the need to dispense the medicines in their original pack. The RP said that they would refer people to their GP if they needed to be on the PPP and weren't on one.

The RP said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and lithium. Prescriptions for higher-risk medicines were highlighted. Team members said that they checked with the RP before handing these out so that he could speak with people about their medicines if needed. The pharmacy offered an appointment-based INR clinic once a week. And home visits were also offered to people who could not attend the pharmacy. The RP said that he worked most days that the pharmacy was open and would allow people to attend outside the allotted clinic appointment day if needed. He said that people's GP would routinely ask the pharmacy to undertake a blood test if needed before a person's medication was changed. The RP had completed all the required training to provide the service and he wrote prescriptions for the supplies. He said that he did not usually have input into the dispensing or checking of the prescriptions from the INR clinic as there was a second pharmacist working on those days. But if he was involved in dispensing the medicines, he explained that he would undertake a final accuracy check after another team member had dispensed the medicines. Records were maintained electronically, and the surgeries were sent monthly updates for their patients.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The admin manager explained the action the pharmacy took in response to any alerts or recalls. 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.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. And short dated items were clearly marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked. The admin manager said that the thermometer would be reset and re-checked after around 15 minutes if the temperature was found to be outside the appropriate range. And the pharmacy's head office would be informed. There was room in one of the fridges to store affected quarantined stock. There was a fridge record keeping flowchart on the front of the fridges so all team members could refer to it easily if needed.

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. Uncollected prescriptions were checked monthly and un-dispensed after around five weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The admin manager said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. 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. Team members said that people requested 'when required' medicines 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 it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had checked each pack. The admin manager said that she would remind team members to initial when they had dispensed a pack so that it would make it easier for the pharmacy to identify who had done this task. Patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines.

The pharmacy supplied medicines to a large number of care homes. These were supplied as original packs with medicines administration record charts. Team members used a communication book to ensure messages to and from the care homes were readily available for all team members. The care homes ordered prescriptions for their residents and the pharmacy received a list of medicines ordered. The pharmacy cross referenced the list against the prescriptions received and informed the care homes if any prescriptions were missing so that they could follow this up with the surgeries. There were several team members involved with the care homes service and could provide cover where needed when other team members were on leave.

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. The pharmacy could track where the driver was on their route and let people know if the driver had their medicine with them. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to

contact the pharmacy to rearrange delivery. A cool box was used to transport medicines requiring refrigeration.

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. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. 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 blood pressure monitor was replaced yearly by the pharmacy's head office. The carbon monoxide testing machine was calibrated at regular intervals. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. The machine used to test people's INR levels was calibrated at regular intervals by an outside agency and the pharmacy kept records of this activity.

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.