General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Northdown Pharmacy, 261/3 Northdown Road, Cliftonville, MARGATE, Kent, CT9 2PN

Pharmacy reference: 1032859

Type of pharmacy: Community

Date of inspection: 12/12/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. And it is part of a small chain of pharmacies. The people who use the pharmacy are mainly older people. And the pharmacy receives around 90% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service and seasonal influenza vaccinations. It also provides medicines as part of the Community Pharmacist Consultation 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

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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 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. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. There was a set of up-to-date standard operating procedures (SOPs) available for team members to refer to where needed. 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 not currently being recorded. The pharmacist said that he had recently discussed this with the team and he printed a near miss log during the inspection. He said that he would ensure that team members recorded their near misses and that he would regularly review them for any patterns. Items in similar packaging or with similar names were separated using card dividers where possible to help minimise the chance of the wrong medicine being selected. The pharmacy had a designated form to record any dispensing incidents. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The pharmacist was in the process of completing the report, but he had discussed the incident with team members.

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.

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 said that she would contact the pharmacy's head office if the pharmacist had not contacted the pharmacy to let them know how late they were expected to be. The MCA knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. But she thought she could sell General Sales List medicines before the pharmacist had turned up. The trainee dispenser was not aware that she should not carry out any dispensing tasks if there was no responsible pharmacist signed in. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

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 emergency supply record was completed correctly and there were signed in-date Patient Group Directions available for the relevant services offered. The pharmacist said that he had not supplied any unlicensed medicines since he started working at the pharmacy. The inspector reminded him about the information that should be recorded when a supply of an unlicensed medicine was made. The private prescription records were largely completed correctly. But the records had not been

kept up to date for the last few months. The pharmacist said that he would ensure that the record was kept up to date in the future. Controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and liquid overage was recorded in the register. The responsible pharmacist (RP) log was largely completed correctly and the correct RP notice was clearly displayed.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used his own smartcard to access the NHS electronic services. But a card belonging to another pharmacist was being used at the start of the inspection. The pharmacist removed this from the docking station and said that he would apply for a smartcard for the trainee dispenser. 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 available on the NHS website. Results were positive and 100% of respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed but details about it were not available in the shop area. The pharmacist explained about a complaint that had been recently received. He said that he dealt with the complaint and the person who had complained was satisfied with how it had been handled.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist gave an example of action the pharmacy 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 team members to provide its services safely. They are provided with some training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, two trainee dispensers, one trained MCA and one trainee MCA working during the inspection. One of the trainee dispensers had worked at the pharmacy for around five months, and the other two trainee members of the team had been working at the pharmacy for fewer than three months. Following the inspection, the pharmacist contacted the pharmacy's head office and the pharmacy's superintendent confirmed that the trainee dispenser had been enrolled on an accredited course. Team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she said 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 said that team members were not provided with ongoing training on a regular basis, but they did receive some. The MCA explained about some training that she had recently completed about children's oral health. The pharmacist explained that he planned to implement a more regular training programme for team members and for each one to have their own training log. He had already implemented an induction training log to ensure that team members had read and understood important SOPs. The pharmacist said that he felt able to take professional decisions. He had completed declarations of competence and consultation skills for the relevant services, as well as associated training.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist explained that as he had not worked at the pharmacy for long, and he was planning to implement a formalised appraisal and performance review system for all team members. Newer team members were being trained on the pharmacy's processes by other team members. They were patient when explaining the processes and they worked well together.

Targets were not set for team members. The pharmacist said that he provided the services 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. 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 a padded bench and chairs in the shop area for people to use. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy had two consultation rooms and both were mainly used by a beautician. The MCA explained that the pharmacist used the rooms when needed and there was always one available. There was a bed in each room and no chairs. The MCA explained that chairs from the shop area were moved into the rooms when needed. Both rooms were suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. One of the consultation rooms was not kept locked when not in use, but there was no personal information or medicines kept in the room. The pharmacist said that he would take adrenaline pens, a sharps bin and any other equipment needed for the appointment and then return them to the dispensary after.

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. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity 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 highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription as no longer valid. 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 the 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. Expiry dates were checked at regular intervals. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock.

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. Uncollected prescriptions were checked weekly. The MCA said that she checked them to ensure that any items for the same person were banded together. Uncollected prescriptions were returned to the NHS electronic system or kept at the pharmacy until they no longer valid. The pharmacist said that the prescriptions would be destroyed appropriately in the pharmacy once no longer valid.

The pharmacist said that he carried out assessments for people who had their medicines in multi-compartment compliance packs to show that they needed them. Prescriptions for people receiving their medicines in these 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 the pharmacy contacted people to see 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 and 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. Team members wore gloves when handling medicines that were placed in these 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. The pharmacy had been reusing dispensing bottles when measuring out some liquid medicines, and these were rinsed with water in between. This meant that people may not be dispensed the correct quantity of liquid or water may have diluted the strength of the medicine. The pharmacist gave assurances that he would not reuse the bottles in the future.

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. 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 undertaken any training on how the system worked. The pharmacist said that he would check with the pharmacy's head office when the pharmacy was likely to 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 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.

Up-to-date reference sources were available in the pharmacy and online. The shredder was 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.