General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Farncray Ltd., 330 High Street, ORPINGTON, Kent, BR6 0NQ

Pharmacy reference: 1032873

Type of pharmacy: Community

Date of inspection: 16/04/2019

Pharmacy context

This is a high street community pharmacy on the main road of a town centre. It is close to a large shopping centre, and there are several other pharmacies nearby. It mainly dispenses NHS prescriptions, and offers other services such as over-the-counter medicines and Medicines Use Reviews. It assembles multi-compartment compliance aids to help people take their medicines.

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

The pharmacy generally manages the risks associated with its services. But it does not regularly review dispensing incidents for any patterns or trends. This could mean that it misses out on opportunities to learn and improve safety. It mostly keeps the records it needs to by law. The pharmacy generally protects people's personal information. But it does not always dispose of confidential waste appropriately. This could potentially mean that people's personal information is not protected properly. Team members know how to safeguard vulnerable people.

Inspector's evidence

A range of standard operating procedures (SOPs) was in place, but they were from various sources and were a little disorganised. This could make it harder for team members to locate a specific one. Staff had read and signed the SOPs relevant to their role. The pharmacist (who was also the superintendent; SI) showed new SOPs he was working on. These included how to use the systems for the Falsified Medicines Directive (FMD).

Dispensing errors were recorded on the computer system. The SI explained how they recorded near misses in a paper format. But said that he had taken the previous records home to help him prepare for an NHS declaration. The only near miss record found was one incident which had been written on a loose piece of paper. The near misses were not reviewed on a regular basis for any patterns or trends, but the SI said that he would do this going forward. He showed a form they would use to fill in near misses on an ongoing basis. A near miss had occurred between two different types of eye drops, and the SI said that they had been separated from each other. However, they were found next to each other on the shelves. The SI separated them again and informed the technician. The technician said that he had just done date checking on that section and thought that is why they ended up back together.

The SI said that there had been a prescribing error where a weekly patch had been prescribed daily. He said that he had reported this to the prescriber. The pharmacy kept an audit trail for deliveries, where people signed to indicate safe receipt. The signatures were obtained on separate pages to help protect people's personal details.

The medicines counter assistant (MCA) was clear about her own role and responsibilities. But she was not fully clear about what she could and could not do if the responsible pharmacist (RP) did not turn up in the morning. The inspector reminded her of the activities that could and could not be done.

The pharmacy did an annual survey for people using the pharmacy. The results from the previous one were positive, with around 98% of respondents rating the pharmacy as very good or excellent overall. The NHS complaints procedure was in the SOP folder. The SI showed that details of how to make a complaint were in the practice leaflet. But the leaflets had run out, so he said that he would print some more.

The pharmacy had current indemnity insurance in place. There were two RP notices displayed; the wrong one was covered up when this was highlighted. The RP log, emergency supply records, private prescription records, and specials records examined complied with requirements. The controlled drug (CD) registers largely complied, but one of the registers was of the 'old' format which did not comply

with current legislation. This could mean that all the required information may not be available if there was a future query. The SI said that the register would be closed and a new one started. Some CD running balance checks had been done, but they were not always done regularly for all CDs.

The SI said that the pharmacy had a shredder, but that he had temporarily taken it home. He said that it would be brought back as soon as possible. Two dispensing labels had been ripped up and put into general waste, and some people's details were visible. These were immediately removed. The consultation room was in the back of the pharmacy and off the shop floor. On the way, there were boxes of dispensed medicines, and from certain angles people's details could potentially be seen. The SI said that they would obtain larger boxes to prevent this. He said that people were always escorted straight to and from the room.

Computer screens were turned away from people. Staff had individual Smart cards to access the NHS electronic systems. Staff had read and signed the guidance on safeguarding vulnerable people. They were able to describe what they would do if they had any concerns. They had access to contact details for local safeguarding agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members for its services. They do ongoing training. This helps keep their knowledge and skills up to date. They can make suggestions or raise any concerns. So, they can help improve the pharmacy's services.

Inspector's evidence

At the time of the inspection there was one pharmacist (SI), one pharmacy technician, and one MCA. They were able to describe what accredited training they had done. The pharmacy also employed another regular pharmacist. Dispensing was up to date, and the pharmacy was relatively quiet but steady during the inspection.

The SI and technician felt able to comply with their own professional and legal obligations. They gave an example of a person who had been prescribed a scalp application instead of a cream. This was queried with the prescriber, and a new prescription issued.

The MCA showed the ongoing training she had done. She kept a record of when she had been through training packs and material provided by suppliers and manufacturers. And she was able to describe what she had learned about medical conditions and medicinal products. She explained how she questioned people requesting a medicine over the counter, and how she would refer people to the pharmacist. She felt able to make suggestions or raise concerns with the SI, who often worked in the pharmacy. There was a small team in the pharmacy, and staff said that they discussed any issues as they arose. There were no formal targets in place for staff.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally suitable for the pharmacy's services. But some areas of the pharmacy require maintenance or cleaning. These detract from the overall appearance of the pharmacy.

Inspector's evidence

The pharmacy was generally clean and tidy. It had not received a refit for some time, and this was reflected in the state of some of the fixtures and fittings. However, it was generally in an acceptable state of repair. The odd ceiling tile was stained, and some shelf edgings were peeling off due to recent water damage. The SI said that they would be replaced.

The consultation room was away from the shop floor. It was small, but of adequate size. It allowed a conversation to take place inside which would not be overheard. There was a chair available for people who wanted to wait for prescriptions. This was close to the counter, which made it more likely that people could overhear conversations on the counter. The SI said that they would move it further away against one of the walls. The chair itself was in a poor state of repair, and another seat in a cushion cover had been put over the damaged seat. The SI said that they would obtain a new chair.

The room temperature in the pharmacy was suitable for the storage of medicines. Handwashing facilities were available. The staff toilet area was dirty in parts, and the room had peeling paint and some mould. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides the services safely and mostly manages medicines well. It takes the right action when safety alerts are received. This helps ensure that people get medicines and devices which are safe to use.

Inspector's evidence

The pharmacy had step free access from the street, and there was a bus stop outside. The MCA described how she signposted people to other local services, and kept further information in a folder. She said that she signposted people who needed sharps disposal to the local service who collected from the person's home.

Dispensed multi-compartment compliance aids were labelled with a description of the medicine. Not all the compliance aids had an audit trail to indicate who had dispensed and checked the items. This could make it harder for the pharmacy to show who had done each task if there was a query. Patient information leaflets (PILs) were routinely supplied. This helped people have the information they needed to take their medicines safely. The technician showed they kept an audit trail of when people collected their complinc aids or had them delivered. He said that any communication with the prescriber or when people's medicines changed were recorded on the patient medication system. But he was unable to find any recent examples. He said that he would review the system to ensure that the information was recorded.

The SI and technician were aware of the additional advice to be provided with valproate medicines. And the pharmacy had the relevant literature such as cards and leaflets. The SI said that he had spoken to one person about the Pregnancy Prevention Programme. He said that they dispensed prescriptions for CDs when the person came in for them. He explained that they put a note on the bags when they contained items such as higher risk medicines. But none were seen in the retrieval system. Prescriptions were not routinely kept with dispensed medicines. This could make it harder for the pharmacist to know any further details when counselling people collecting their medicines.

The MCA explained how she showed people collecting medicines their address to check it was them. But said that she knew most of the people anyway. The SI said that he had been concerned that asking people for their address may be contrary to the General Data Protection Regulation. But he said that he would seek further advice and review the system.

The pharmacy had the equipment for the Falsified Medicines Directive (FMD) and the staff were actively using it. The pharmacy obtained medicines from licenced suppliers. The medicines were stored in a tidy and orderly manner on the shelves. Stock was date checked regularly, and records were kept for this. No date-expired medicines were found in with stock. Medicines for destruction were segregated into designated bins and sacks, then collected by a specialist contractor.

CDs were kept in a secure place. Medicines which needed cold storage were kept in a fridge, and the temperatures were recorded daily. A sign was next to the fridge which explained what to do if the temperature went out of range.

The pharmacy got drug alerts and products recalls via email, and the technician was able to name recent ones they had received. And how they had checked the stock as a result. A record was not always made of the action that had been taken. This could make it harder for the pharmacy to show that it took the right action in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for the services it provides.

Inspector's evidence

A calibrated glass measure was available for liquids, but it was slightly scaled. The staff said that they would clean it. It could not measure less than 10ml. A new one was ordered in during the inspection. The electronic tablet counter was clean. But it was not clear if it had recently been safety tested. The SI said that this would be arranged.

Empty dispensing bottles were capped to prevent contamination. The fax machine was away from the shop area, and the phone could be moved somewhere more private to protect people’s personal information. Medicine reference sources were available online.

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.