General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 25 High Street, Lydd, ROMNEY MARSH, Kent, TN29 9AL

**Pharmacy reference:** 1032896

**Type of pharmacy:** Community

**Date of inspection:** 29/03/2023

## Pharmacy context

The pharmacy is on a high street in a largely residential area. It offers a range of services, including the New Medicine Service, flu vaccinations and blood pressure checks. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. and it receives most of its prescriptions electronically.

## 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And it largely protects people personal information well. The pharmacy mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy up-to-date standard operating procedures (SOPs) and team members had signed to show that they had read, understood, and agreed to follow them. Near misses, where a dispensing mistake was identified 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. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The pharmacy's head office was informed and learning points were shared with other pharmacies in the group.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And the team kept workspace in the dispensary free from clutter. The pharmacy used baskets to help 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.

Team members said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. One of the team said that she would not sell medicines or hand out bagged items if there was no responsible pharmacist (RP) signed in. But she thought that bagged items could be handed out if the pharmacist was not in the pharmacy. The inspector reminded team members what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. The responsible pharmacist (RP) record was completed correctly, and the right RP notice was displayed. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The private prescription records were largely completed correctly, but the patient's address and the prescriber's address were not recorded. The pharmacist said that she would ensure that this was recorded in future. The pharmacist said that she had not made any supplies of a prescription-only medicine in an emergency without a prescription since working at the pharmacy. She was not sure where they should be recorded and said that she would check with the area manager.

People's personal information on bagged items waiting collection could not be viewed by people using

the pharmacy. Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens in the dispensary. But the computer screen in the unlocked consultation room was displaying some people's personal information. The pharmacist said that she would ensure that the room was kept locked in future. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. There had been a few complaints about how short-staffed the pharmacy has been and how the services were not being managed properly. And staff had received some abuse from people. The area manager had been addressing the concerns and had been providing additional staff to help the pharmacy manage its workload.

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 pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members said that there had not been any recent safeguarding concerns at the pharmacy.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has just enough team members to provide its services. And it receives support from its head office to ensure that there are enough team members to manage the workload. They can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe.

### Inspector's evidence

There was one pharmacist and one relief dispenser working at the start of the inspection. The pharmacist said that the pharmacy had experienced staff shortages recently. She explained that team members had stayed after the pharmacy had closed the previous day. This meant that the pharmacy had caught up on its dispensing and other tasks. And as a result, some team members had been allowed time off on the morning of the inspection. A dispenser from a local pharmacy in the company had been asked to work at the pharmacy to help during the inspection. And one of the dispensers said that some team members were due to work late on the day of the inspection. The pharmacy was in the process of recruiting more staff. Following the inspection, the pharmacy's area manager provided assurances to the inspector that the pharmacy would continue to receive support.

Team members appeared confident when speaking with people. One when asked, said that they were only allowed to sell one box of pseudoephedrine-containing products at a time. 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. Team members used 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. She said that team members did not currently have time to undertake training at work due to the current workload. But they did receive some training modules, and these could be done in their own time. The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she felt able to take professional decisions.

The team said that the pharmacy’s area manager regularly visited the pharmacy to ensure that the pharmacy was receiving the support it needed. And there were regular team meetings to discuss any ongoing issues and allocate tasks. Team members had yearly appraisals and performance reviews. The pharmacist felt able to discuss any issues with the area manager. She had started working at the pharmacy around six weeks ago when the pharmacy was short-staffed and felt supported by the pharmacy’s head office. Targets were not currently set for team members.

## Principle 3 - Premises ✔ Standards met

### Summary findings

People can have a conversation with a team member in a private area. And the premises 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. It was bright, clean, and generally tidy. Pharmacy-only medicines were kept behind the counter or behind clear screens in the shop area with ‘please ask for assistance’ displayed. 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, and the room temperature was suitable for storing medicines. There were several bagged items on the floor in the dispensary. The pharmacist said that these had been prepared the previous evening and were due to be placed in the retrieval system. She confirmed that the floor areas were usually kept clear.

There were a couple of 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. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened and conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was not kept secure at the start of the inspection. There were some medicines in an unlocked fridge in the room. The pharmacist said that she would ensure that the room was kept locked when not in use in future.

## 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. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. And the pharmacy dispenses medicines into multi-compartment compliance packs safely.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power-assisted door. 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 she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. The 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. The pharmacist said that the pharmacy supplied valproate medicines to a small number of people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). She said that she would refer a person to their GP if they were not on a PPP and needed to be on one.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. 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 few months and this activity was recorded. Stock due to expire within the next several months were marked. There were a few date-expired items found in with dispensing stock. But these were clearly marked. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. The pharmacy stored its CDs stored in accordance with legal requirements and kept them 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, and two signatures were recorded.

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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around six 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 pharmacist said that people had assessments carried out by their GP 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. Prescriptions for 'when required' medicines were not routinely requested. One of the dispensers said that the pharmacy contacted people to ask 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 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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded on a hand-held electronic device which ensured that people's personal information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And the person was sent a text message to let them know that they had missed the delivery.

## 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 and counting tablets was available and clean. One of the dispensers said that the triangle tablet counter was washed after each use to help avoid any cross-contamination. Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor would be replaced in line with the manufacturer’s guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed.

## 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. |