General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Focus Chemists, 126 Borstal Street, Borstal, ROCHESTER, Kent, ME1 3JS

Pharmacy reference: 1032900

Type of pharmacy: Community

Date of inspection: 09/07/2019

Pharmacy context

The pharmacy is located on a small parade of shops in a small village. It is opposite a doctors surgery and near to a sheltered housing complex with around 40 residents. The nearest large town is Rochester which is around two miles away. The people who use the pharmacy are mainly older people. The pharmacy receives around fifty per cent of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, and uses a patient group direction for the influenza vaccine (seasonal). It provides medicines to people using the NHS Urgent Medicine Supply Advance Service. And it provides multi-compartment compliance packs to around twenty people who live in their own homes and one care home with around sixty beds, to help them take their medicines safely. It provides substance misuse medicines to two 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

The pharmacy generally identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information. It regularly seeks feedback from people who use the pharmacy. And it mostly keeps its records up to date. 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. The pharmacy has some written instructions which tell the team how to work safely. But superintendent (SI) pharmacist could not locate ones to cover all the topics required by law. This could mean that the pharmacy team doesn't always know what to do if the pharmacist isn't there or the best way to complete tasks. The SI said that he was in the process of reviewing all procedures and would ensure that all required by law were made available.

The SI said that a near miss log was kept but he could not locate it during the inspection. He said that near misses were highlighted with the team member involved at the time of the incident. And they identified and rectified their own mistakes. Items in similar packaging were separated where possible. The SI said that a recent incident had occurred where a wrongly labelled medicine had been supplied to a person. There were two people with similar names taking similar medicines. He said that this dispensing incident had been reported on the National Reporting and Learning System by a locum pharmacist. And he confirmed that he would use the newly installed computer system to record any future incidents.

Workspace in the dispensary was generally free from clutter. There was an organised workflow which helped the SI to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The SI signed the dispensing label to show that he had dispensed and checked each item.

The medicines counter assistant (MCA) informed people that the pharmacist was not on the premises at the start of the inspection. She let them know that they could not collect dispensed items but allowed them to drop off prescriptions. And she let them know what time their medicines could be collected. She thought that she could sell general sales list medicines before the pharmacist had turned up. But said that she would not sell pharmacy-only medicines. 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. All necessary information was recorded when a supply of an unlicensed special was made. The date on the prescription and the full prescriber' details were not always recorded on the private prescription record. 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. The SI said that he would ensure that these records were completed correctly in the future. Controlled drug (CD) running balances were checked around once a month. Liquid methadone balances were checked every

two weeks; overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The pharmacists did not usually complete the responsible pharmacist (RP) log when they had finished their shift. The SI had not completed the log at the end of his shift yesterday. And the MCA had completed the log on the day of the inspection before the pharmacist had turned up. The SI said that she would ensure that the log was completed correctly in the future. 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 SI used his own smart card to access the NHS electronic services. But his smart card had been left in the computer overnight. He said that he would ensure that his smart card was kept securely when he was not in the pharmacy. Dispensed items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the recent surveys were displayed in the shop area and the 2017 to 2018 survey was available on the NHS website. Results showed that 100% of respondents were satisfied with the pharmacy overall. The SI said that he was not aware of any received any recent complaints. And the complaints procedure was displayed in the shop area.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed training provided by the pharmacy. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI said that there had not been any safeguarding concerns at the pharmacy. 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 help keep their skills and knowledge up to date. They can raise any concerns or make suggestions to 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 (who was the SI), one MCA and one trainee MCA working during the inspection. The MCA had completed an accredited counter assistant course and the trainee MCA had been enrolled on a course. The trainee MCA said that she sometimes worked in the dispensary and had been selecting stock for prescriptions. She had worked at the pharmacy for around three years. The SI said that he would enrol her on an accredited dispensers course so that she could work in the dispensary. He said that the full-time dispenser was on leave for four weeks and he was working alone in the dispensary most of the time. Team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She said that she would refer to the pharmacist before selling most pharmacy-only medicines. Or, 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 MCA said that she was not provided with ongoing training on a regular basis, but she received product information from suppliers. And she said that she refreshed her knowledge using the course work from the medicines counter assistant course she had completed in 2002. She was unsure whether the information from her course was still current. The SI said that he would investigate some online training courses. And he would monitor training to ensure that team members understood the information.

The pharmacy received a request for an emergency supply of a medicine via the NHS 111 NUMSAS. The person was visiting the UK from another country. The SI spoke with the person's relative and checked the NUMSAS protocols before deciding whether to make the supply. As the person had not previously had the medicine on an NHS prescription, the SI decided that the supply would not be made. He said that he would refer the person to a local NHS walk-in centre.

Team members appeared to have a good working relationship with the SI. The trainee MCA said that she felt confident to discuss any issues with him. She said that there were informal performance reviews but these were not documented. She confirmed that meetings were sometimes held when the pharmacy was closed so that team members could discuss any issues.

Targets were not set. The SI said that he carried out services for the benefit of the people who use the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

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. 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 were two 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. But these were positioned near the consultation room. Some conversations in the consultation room could be heard from the shop area. The SI said that he would ensure that people were informed about this when using the room.

The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped and well-screened. The room was not kept secure when not in use. There were a few sharps bins in the room. One had used sharps exposed. This was removed from the consultation room during the inspection and placed for disposal. The SI said that he would ensure that in-use sharps bins were not kept in the room in future.

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

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was one small step 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. A variety of health information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that he checked monitoring record books for people taking high-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 relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. And prescriptions were not always kept at the pharmacy until the medicines had been collected. This could make it harder for the team members to refer to the original prescription if there were any queries. Or to know if the prescription was still valid when handing out the medicines. The SI said that he would ensure that prescriptions were kept for dispensed items in future. He said that CDs and fridge items were checked with people when handing them out. He confirmed that people in the at-risk group who were taking valproate medicines were provided with warning cards and patient information leaflets. He said that he would ensure that all females were provided with these in future each time they were given valproate medicines. He confirmed that there were no people in the at-risk group who needed to be on the Pregnancy Prevention Programme.

Stock was stored in an organised manner in the dispensary. The SI said that expiry dates were checked every three months and this activity was recorded. Short-dated items were not marked. Several medicines were found which were not kept in their original packaging. And some of the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. There were a few mixed batches found with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. A box of medicines found with dispensing stock had expired at the end of June 2019. The trainee MCA said that she would keep a record of short-dated items so that these could be removed promptly. This would help to reduce the chance of out-of-date medicines being supplied to people.

The SI said that part-dispensed prescriptions were not checked regularly. Prescriptions were not kept at the pharmacy until the remainder was dispensed. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of errors. '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. The SI said that uncollected prescriptions were checked every two weeks and items uncollected after around one month were usually returned to dispensing stock when possible. Prescriptions were not

always kept with the items until these were collected. The SI said that some of these prescriptions had been sent to the NHS. He confirmed that people's medication records were updated to show that they had not collected their medicines and prescriptions were usually shredded.

Prescriptions for people receiving their medicines in 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; the SI said that the pharmacy usually contacted people to see if they needed them. The pharmacy kept a record for each person which included any changes to their medication. Packs were generally labelled correctly and medication descriptions were put on the packs. But cautionary and advisory warning labels were not recorded on the backing sheets. And patient information leaflets were not routinely supplied. This could make it more difficult for people to know how to take their medicines safely. There was an audit trail to show who had checked each pack. But there was no audit trail to show who had dispensed each pack. The SI said that there was only one member of the dispensary team who assembled the trays. The SI said that he would review the procedures to ensure that the packs were supplied safely. He said that the care home was responsible for ordering prescriptions for their residents. The pharmacy received a copy of which items had been ordered and could check that prescriptions for all items was received. The SI visited the care home regularly to ensure that the medicines were being supplied safely.

CDs were generally 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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible; these were recorded in a way so that another person's information was protected. Failed deliveries were returned to the pharmacy before the end of the working day. And a card was left at the address instructing the patient to contact the pharmacy to rearrange delivery. The SI said that the delivery book with people's names in was not left at the pharmacy at the end of the driver's shift. He confirmed that he did not know if it was held securely and protected from unauthorised access. He said that he would ensure that the delivery driver returned this to the pharmacy at the end of her shift in the future.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS, MHRA and suppliers. Action taken was sometimes recorded and kept for future reference. But this did not always happen. The SI said that he would keep a record in the future.

The pharmacy had the equipment installed for the implementation of the EU Falsified Medicines Directive. The SI said that the pharmacy had written procedures to cover this process. The equipment was not being fully used yet.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Suitable equipment for measuring medicines was available. The SI said that a separate measure was usually marked methadone use only. But he was waiting for a replacement measure. He washed the measure thoroughly after each use. 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 pharmacist said that the blood pressure monitor was replaced every two years. 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 usually checked daily; maximum and minimum temperatures were recorded. The fridge temperatures had not been recorded for around one week. The SI said that this was usually done by the dispenser who was on leave. The trainee MCA said that the computer had not prompted for this information to be recorded when it was turned on. The SI said that he would contact the system provider to find out why the prompt was not being displayed. Previous records indicated that the temperatures were consistently within the recommended range. And the temperatures were within the recommended range on the day of the inspection. The fridges were 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.