General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Targett Chemist, 172 Halfway Street, SIDCUP, Kent, DA15 8DJ

Pharmacy reference: 1032947

Type of pharmacy: Community

Date of inspection: 29/04/2021

Pharmacy context

The pharmacy is located on a parade of shops on a main road in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives the majority of its prescriptions electronically. It provides a range of services, including the New Medicine Service and seasonal influenza vaccinations. And it 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. The inspection took place during the Covid-19 pandemic. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 adequately identifies and manages the risks associated with its services to help provide them safely. It keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people. They record and review their mistakes so that they can learn and make the services safer. The pharmacy generally protects people's personal information well. But it could do more to make sure that this information is sufficiently protected at all times.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. The pharmacy had carried out workplace risk assessments in relation to Covid-19 and it had documented, up-to-date standard operating procedures (SOPs) available. 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. Team members identified and rectified their own mistakes. The dispenser showed how near misses were recorded and that they were reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the shelf edges where these medicines were kept were highlighted. The responsible pharmacist (RP) explained how he would record a dispensing error (where a dispensing mistake had reached a person). He said that he would carry out a root cause analysis of the error, inform the superintendent pharmacist and record it on the National Reporting and Learning System. He was not aware of any recent dispensing errors.

Workspace in the dispensary was limited, but it was free from clutter. And 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. There were several team members involved in the dispensing process and this allowed for several checks to be carried out. The medicines were dispensed by one of the team, clinically checked and accuracy checked by the RP and then checked and bagged by one of the medicines counter assistants (MCAs). This helped to minimise the chance of a dispensing error being handed out.

The trainee MCA said that team members would not be able to gain access to the pharmacy if the pharmacist had not turned up. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the RP was not in the pharmacy. The dispenser clarified with the inspector that there had to be a RP signed in before certain tasks could be carried out.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. And the private prescription records and emergency supply records were completed and up to date.

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. Some team members did not have their own smartcards. The

dispenser said that an application had been made for one, but this had been delayed due to the pandemic. Some bagged items waiting collection could be accessed to the side of the medicines counter at the start of the inspection. The inspector discussed this with the counter staff, and the items were moved. A box of prescriptions and dispensing tokens was kept on the medicines counter at the start of the inspection, but this was moved so that it could not be accessed by people using the pharmacy.

The pharmacy had carried out patient satisfaction surveys prior to the pandemic. The complaints procedure was available for team members to follow if needed. The trainee dispenser said that she would refer any complaints to the RP. The dispenser said that there had not been any recent complaints about the pharmacy or its services.

The RP had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members said that they had received some safeguarding training. And the dispenser could describe potential signs that might indicate a safeguarding concern and she would refer any concerns to the pharmacist. The RP 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. The team members can take professional decisions to ensure people taking medicines are safe. They are provided with some ongoing training and they are able to raise concerns about the pharmacy.

Inspector's evidence

There were two pharmacists working at the start of the inspection. One was the RP and there was a second pharmacist who was present at the start of the inspection, but left soon after. Also present during the inspection were, one trained dispenser, one trainee dispenser and three trainee MCAs. Most team members had completed an accredited course for their role and the rest were undertaking training. The trainee dispenser was a trained MCA and had worked in the dispensary for around one month. The inspector discussed with her about the timeframe to be enrolled on an accredited course. The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCAs appeared confident when speaking with people. One said that she would refer to the RP if a person requested to purchase more than one box of any pharmacy-only medicine. Or if a person regularly requested to purchase medicines which could be abused or may require additional care. The MCAs asked appropriate questions before selling medicines to establish whether the medicines were suitable for the person.

The trainee MCAs explained that they had been enrolled on the counter course, but they were struggling to find time to finish. And this was due to the increased workload during the ongoing pandemic. They had applied for an extension as they thought they might be running out of time. They had to do the coursework in their own time as there was limited spare time during the day. The pharmacy counter was busy during the inspection and there were three staff covering it. The RP was aware of the continuing professional development requirement for the professional revalidation process. He explained that he had recently completed the online and face-to-face training for the flu vaccination service.

The team members were not currently provided with ongoing training on a regular basis, but they did receive some. The dispenser said that the RP passed on information and the pharmacy sometimes received information about new products. The RP felt able to take professional decisions. The dispenser felt comfortable about discussing any issues or concerns with the pharmacist. And there were daily informal huddles to discuss and allocate tasks. And team members had ongoing informal appraisals. There were no formal targets set for team members.

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. 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. The room temperature was suitable for storing medicines.

A one-way system was marked on the floor in the shop area to help people maintain a suitable distance from each other. And there were screens at the medicines counter to help minimise the spread of infection. And a notice was displayed at the counter to ask that people do not lean over when speaking with team members.

There was a small seating bench in the shop area for people to use. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacy's consultation room was accessed via the side of the medicines counter. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area.

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

The pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. And the pharmacy dispenses medicines into multi-compartment compliance packs safely. It highlights prescriptions for higher-risk medicines, so that there is an opportunity to speak with people when they collect these medicines. The pharmacy gets its medicines from reputable suppliers and largely 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.

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 dispenser explained that people wanting to return some types of controlled drugs (CDs) were signposted to other local pharmacies. And they were signposted if they had a prescription for these medicines.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The RP 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 relevant patient information leaflets and warning cards were available and the RP confirmed that these were supplied when needed. The RP said that he highlighted prescriptions for higher-risk medicines, such as warfarin or methotrexate. This meant that he had the opportunity to speak with these people when they collected their medicines. He checked monitoring record books for people taking these medicines, but he did not keep a record of the blood test results. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Items due to expire within the next few months were marked. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date check the stock properly or respond to safety alerts appropriately. And this was discussed with the dispenser who provided assurance that the medicines would be kept in appropriately labelled packaging in the future. There were some Schedule 3 CDs found in one of the pharmaceutical waste bags. The inspector discussed this with the RP and he said that he would remind team members about the need for these to be denatured before disposal. There were lists above the bin area to show team members which medicines required to be disposed of in this manner.

Part-dispensed prescriptions were checked frequently and 'owings' notes were provided when prescriptions could not be dispensed in full. People were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. This meant that team members could to refer to the original prescription to help minimise the chance of errors when

dispensing the remainder. Uncollected prescriptions were checked regularly and any items uncollected after around six weeks were returned to dispensing stock where possible. And prescriptions were returned to the NHS electronic system or to the prescriber.

Assessments were carried out for the people who wanted to have their medicines in multi-compartment compliance packs to show that they needed the packs. The pharmacy ordered prescriptions for people receiving their medicines in these packs 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 people usually contacted the pharmacy when they needed these medicines with their packs. 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. Medication descriptions were put on the packs to help people and their carers identify the medicines, and patient information leaflets were routinely supplied.

The pharmacy offered a delivery service to those people who were not able to access the pharmacy. These were usually made by the second pharmacist. People were not currently asked to sign for their medicines due to the ongoing pandemic. 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 via email. The RP 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.

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 and 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 appeared to be in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. Personal protective equipment was available and team members wore masks and used hand sanitiser while at work.

Fridge temperatures were checked daily. 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.

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.