General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Roadnight Pharmacy, 88 Station Road, SIDCUP, Kent, DA15 7DU

Pharmacy reference: 1032954

Type of pharmacy: Community

Date of inspection: 04/02/2020

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service. And it provides travel vaccinations, influenza vaccinations (seasonal) and emergency hormonal contraception in accordance with patient group directions. It also provides medicines as part of the Community Pharmacist Consultation Service. 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. 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	1.2	Good practice	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
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 appropriately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information and people can provide feedback about the pharmacy's services. And 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 largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. 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 recorded and 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. Two medicines with similar names (enalapril and escitalopram) were now kept on separate shelves due to incorrect selection of these. The outcomes from the near miss reviews were discussed openly during the regular team meetings. Dispensing incidents where the product had been supplied to a person were recorded on a designated form and a root cause analysis was undertaken. The pharmacist confirmed that there had not been any recent incidents.

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 pharmacy technician said that the pharmacy would open if the pharmacist had not turned up in the morning. She knew that she should not carry out any dispensing tasks, sell any medicines or hand out any dispensed items until the pharmacist had arrived. The medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

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 medicine was made. The emergency supply records were completed correctly and there were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were largely filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. This was discussed with the pharmacist during the inspection.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive overall and 100% of respondents were satisfied with the time taken to be served and the efficient service. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that there had not been any recent complaints.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed some training provided by the pharmacy's head office and the MCA had completed Dementia Friends training. The MCA 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. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. 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. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one pharmacy technician, one trained dispenser, one trainee dispenser and two trained MCAs working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The team members wore smart uniforms with name badges displaying their role. They 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 and she was aware of the restrictions on sales of pseudoephedrine containing products. 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. She explained the questions she would ask a person who wanted to buy an over-the-counter medicine, to establish whether the medicines were for them.

Team members were not provided with ongoing training on a regular basis, but they did receive some. The MCA said that she received information from suppliers about new products and the pharmacist had discussed with her about the new prescription exemptions. She discussed training materials including 'Training Matters' which she completed at home. Other team members also mentioned that they had to complete training at home. The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacy technician said that she had recently completed the sepsis and risk management training provided by the CPPE. Team members also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist said that she felt able to take professional decisions. She had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members said that they had yearly appraisals and performance reviews with the superintendent pharmacist. They felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said that the pharmacy held a meeting around every three months. And team members discussed any ongoing issues or staff training.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that the pharmacy usually reached the targets and she did not feel under pressure to achieve them. She said that she carried out these services for the benefit of the people using the pharmacy and not to meet the targets.

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 were two chairs in the shop area. The MCA said that she would offer the use of the consultation room if a person asked to speak with a member of the team in a more private setting. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. 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

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, so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. And it dispenses medicines into multi-compartment compliance packs safely. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities 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. A bell at the entrance was at a suitable height for wheelchair users and it was in good working order.

The pharmacist said that she 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 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. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that she would ensure that prescriptions for higher-risk medicines and CDs were highlighted in the future. The pharmacist said that the pharmacy supplied valproate medicines to one person in the at-risk group who needed to be on the Pregnancy Prevention Programme. She said that the she had spoken with the person and they were aware of the risks associated with taking the medicine. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were marked. Lists of short-dated items were kept so that these items could be removed from dispensing stock before they had expired. 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. There were several boxes which contained mixed batches found with dispensing stock. 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. The pharmacist said that she would remind team members to ensure that medicines were kept in their original packaging in the future.

Part-dispensed prescriptions were checked daily. '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. The pharmacist said that uncollected prescriptions were checked every three months and people were sent a text message to let them know

that their items were ready for collection. 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's GPs carried out their assessments to show that they needed their medicines in multi-compartment compliance packs. 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 dispenser said that she 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.

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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for some deliveries and these were recorded in a way so that another person's information was protected. But the pharmacy did not obtain signatures for all deliveries and this could make it harder for the pharmacy to show that these medicines were safely delivered. The pharmacist said that she would discuss this with the delivery driver. 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 driver returned all medicines and people's information to the pharmacy before the end of their shift.

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 fully used. The pharmacist said that she had undertaken some training on how the system worked. And she said that team members would require some refresher training before the implementation.

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 and a separate measure was 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. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

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