General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 85-89 East Street, SITTINGBOURNE, Kent, ME10 4BL

Pharmacy reference: 1032960

Type of pharmacy: Community

Date of inspection: 16/04/2019

Pharmacy context

The pharmacy is in a residential area at the bottom end of a busy high street in the centre of a large town. There is a doctor's surgery opposite the pharmacy. The pharmacy gets most of its prescriptions electronically. But the pharmacy still has a lot of people who bring their prescriptions by hand. It provides a range of services including preparing multi-compartment compliance packs to people who live in their own homes.

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 identifies and manages the risks associated with its services. It keeps records required by law, but they are not always complete. So, they may not be reliable in the event of a future query. It actively seeks feedback from the public. And team members understand their role in protecting vulnerable people. The pharmacy generally protects people's personal information.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy 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 online and reviewed regularly for trends and patterns; learnings were shared throughout the organisation. Medicines in similar packaging or with similar names were separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The report did not contain a detailed account of any action taken. The medicines were already kept separate on the shelves.

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. The pharmacist requested a second check for items she had dispensed.

Team members roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would not open if the pharmacist had not turned up. She knew that she should not sell any pharmacy only medicines or hand out bagged items if the pharmacist was not on the premises.

The pharmacy had current professional indemnity and public liability insurance in place. 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. Signed in date patient group directions were available for the services offered. A private prescription dated 1 April 2019 and dispensed on 8 April 2019 did not have the prescriber's address recorded. The prescriber's details were not routinely recorded in 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. Controlled drug (CD) running balances were checked weekly. The recorded quantity of one item checked at random was the same as the physical amount of stock available. Some alterations in the CD registers were not marked with the reason or who had made the alteration. The address of the supplier was not routinely recorded in the registers. The responsible pharmacist (RP) record was completed and the correct RP notice was clearly displayed.

Confidential waste was removed by a specialist waste contractor and people using the pharmacy could not see information on the computer screens. Computers were password protected. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The

pharmacy team members had completed General Data Protection Regulation training. Some confidential material was kept in an unlocked filing cabinet. This could make it harder for the pharmacy to show that it is keeping this safely.

The pharmacy carried out yearly patient satisfaction surveys; results were available in the shop area and on the NHS website. Results were generally positive with over 70% of respondents satisfied with the pharmacy overall. The dispenser said that she was not aware of any complaints. 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 online training provided by the pharmacy. The dispenser 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 dispenser said that she was not aware of any safeguarding concerns at the pharmacy since she started working there around twenty months ago.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training. But they are not always given time set aside for training. This may limit the opportunities they have to keep their knowledge and skills to up to date. They can raise any concerns or make suggestions and have regular meetings. 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 relief pharmacist, one dispenser and one relief dispenser working during the inspection. The relief dispenser was enrolled on the NVQ level 3 pharmacy course. The pharmacist said that a permanent pharmacist was due to start in May 2019. The relief dispenser said that the pharmacy had been without a permanent pharmacist since February 2019. From 8.30am to 9am there was the pharmacist and dispenser working; they had to cover the medicines counter while dispensing and carrying out other tasks. The team 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 dispenser appeared confident when speaking with people. 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members had completed accredited pharmacy courses. The dispenser had recently completed the NVQ level 2 course. The relief dispenser said that she did not have time during the working day to complete course work. She that she completed online training modules at home. She had received a message from her manager that she needed to read one of the SOPs before the end of her shift on Wednesday. She said that training was checked by the area manager. The relief pharmacist had completed training required to provide services, but not for Lipotrim (a weight management programme). She said that people taking Lipotrim made appointments to see the member of the team who ran the service. She was unsure who else was trained to provide this service.

The dispenser said that informal meetings were held regularly to discuss any issues and prioritise tasks. She explained that she was due to have a performance review and appraisal. She said that she had a review one month after she started but none in the last 19 months. The relief dispenser said that she had not had a review for over two years. The pharmacist said that she had reviews around every four months.

Targets were set for medicines use reviews (MUR) and new medicine service (NMS). The pharmacist said that she carried out these services for the benefit of the people using the pharmacy and not to meet the targets. She said that she managed to carry out at least two MURs on most days she was working. She said that she did not feel under pressure to meet targets.

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. Pharmacy only medicines were kept behind the counter. The pharmacist had a clear view of the medicines counter from the dispensary through a hatch. She listened to conversations and intervened where needed.

The pharmacy was bright, clean and tidy throughout; this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines. There were four chairs available in the shop area; these were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The fabric on one of the chairs had a large rip down the centre. This detracted a little from the appearance of the pharmacy.

The consultation room was accessible from the shop area. The room was not lockable. The computer was kept locked when not in use. Low level conversations in the consultation room could not be heard from the shop area. The windows in the door were not see through and a blind was used to cover the window. There were three chairs available and the room was suitable for the services. The printer was perched precariously overhanging on a shelf and was propped up using two box files. 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 generally manages its services well. And people with a range of needs can access them. The pharmacy does not always highlight prescriptions for schedule 4 controlled drugs and does not always remove expired prescriptions promptly. This could increase the risk of these medicines being supplied when the prescription has expired. The pharmacy gets its medicines from reputable suppliers. And generally stores them safely and manages them well. But it does not always remove expired medicines promptly. And does not always keep medicines in appropriately labelled containers. This could increase the chance of expired medicines being supplied. And may mean that it cannot take appropriate action when there is a medicine recall or alert.

Inspector's evidence

There was step free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of patient information leaflets were available in the consultation room and shop area. Services and opening times were clearly advertised. The induction hearing loop appeared to be in good working order.

The pharmacist said that she checked monitoring record books for people taking high risk medicines such as methotrexate and warfarin. She said that she recorded results on the persons medical record. Prescriptions for schedule 4 CDs were not routinely highlighted. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that all female patients taking valproate medicines were provided with warning cards and patient information leaflets. The pharmacist was aware of a few patients who needed to be on a pregnancy prevention programme.

Stock was stored in an organised manner in the dispensary. The pharmacist said that the team were in the process of checking expiry dates. Stock with a short expiry was generally marked. But there were several items due to expire in the next few months that were not marked. There were several expired medicines found with dispensing stock and there were some boxes containing mixed batches. Not all prescription only medicines were stored securely. This could make it harder for the pharmacy to restrict access to them.

The pharmacist said that part dispensed prescriptions were checked daily. ‘Owings’ notes were provided and people were kept informed about supply issues. She said that prescriptions for alternative medicines were requested from prescribers where needed. The dispenser said that uncollected prescriptions were checked monthly. She said that people were contacted and items uncollected after a further two weeks were returned to dispensing stock where possible. She said that uncollected prescriptions were returned to the prescriber. An electronic retrieval system had been started recently. The dispenser said that this made it easier for the team to find out where a prescription was and whether it had been dispensed. There were some prescriptions in the old retrieval system. Several prescriptions for CDs had expired.

The dispenser said that the person who managed the multi-compartment compliance packs was due to start at 12.30pm. She said that she was due to be trained on how to manage the system and that the manager had a basic understanding of it. Prescriptions for people receiving their medicines in

compliance packs were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy routinely contacted people to see if they needed them. The pharmacy kept a record for each patient which included any changes to their medication. They also kept hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each tray. Medication descriptions were put on the packs. Patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements. 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.

The pharmacy was using a courier for the delivery service, as the regular driver was not currently working. There was a limit to the amount of deliveries that could be made each day. The dispenser asked the delivery driver to read and sign the delivery SOP before starting work. The pharmacy obtained people's signatures for deliveries where possible; these were recorded in a way so that another person's information was protected.

Only licensed wholesalers were used for the supply of 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. The pharmacy had the equipment available for the implementation of the EU Falsified Medicines Directive. Team members said that they had received training.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Separate measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for methotrexate use only. This helped avoid any cross-contamination. The free health check machine and Smokerlyzer were calibrated by an outside agency. The weighing scales were in good working order. The phone in the dispensary was portable so 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.