General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swanley Pharmacy, 47 Swanley Centre, SWANLEY, Kent, BR8 7TQ

Pharmacy reference: 1032972

Type of pharmacy: Community

Date of inspection: 06/05/2021

Pharmacy context

The pharmacy is in an open-air shopping centre in Swanley town centre. The pharmacy receives most of its prescriptions electronically. It provides a range of services, including the New Medicine Service. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. The inspection was carried out during the Covid-19 pandemic.

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 records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information and people who use the pharmacy are able to provide feedback about its services. Team members understand their role in protecting vulnerable people. 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. It had documented, up-to-date standard operating procedures (SOPs), and systems for reporting and reviewing dispensing mistakes. And it had carried out workplace risk assessments in relation to Covid-19. Near misses (dispensing mistakes which had been 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. Near misses were recorded and reviewed regularly for any patterns, and the team discussed any dispensing mistakes to help make the pharmacy's services safer. A separate record was kept for the trainee dispenser to help him learn from his own mistakes as well as mistakes other people made. 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 (dispensing mistakes which had reached a person) were recorded on a designated form and a root cause analysis was undertaken. The pharmacist was not aware of any recent dispensing errors, but previous ones had been discussed openly in the team.

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 had signed to show that they had read, understood and agreed to follow the SOPs. And their roles and responsibilities were specified. The trainee medicines counter assistant (MCA) was clear about her own roles and responsibilities and understood when to refer people to the pharmacist. She knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The trainee dispenser knew that he should not undertake any part of the dispensing process if there was no responsible pharmacist (RP).

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. Controlled drug (CD) registers examined were filled in correctly, and the pharmacist said that CD running balances were checked regularly. But this had not always been documented recently due to the current workload during the pandemic. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were mostly completed correctly, but the details of the prescriber were not generally recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that he would contact the software provider and find

out how to add these to the computer record. The nature of the emergency was not always 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 pharmacist said that he would ensure these records were completed properly in the future.

Confidential waste was sent to the pharmacy's head office for appropriate disposal. 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 and kept it secured when not in use. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out for 2020 to 2021. Results from the 2019 to 2020 survey were available on the NHS website and these were positive. People were satisfied with the time taken for the pharmacy to provide its services, and with the pharmacy staff. 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 had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. And 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 enrolled on accredited courses for their roles or have already completed a relevant course. They have access to online training to support their learning needs and maintain their knowledge and skills. And they feel comfortable about raising any concerns or make suggestions about the pharmacy's services. Team members can take professional decisions to ensure people taking medicines are safe. And they discuss any dispensing mistakes openly.

Inspector's evidence

There was one pharmacist, one trained dispenser, one trainee dispenser and one trainee MCA working during the inspection. Team members had either completed an accredited course for their role, or they were undertaking appropriate training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The pharmacist said that most team members had received two Covid-19 vaccinations and others were due to have their second dose soon. He explained that team members had been carrying out lateral flow tests until recently. But this would be restarted and they would have twice weekly tests. The inspector discussed the reporting process if a team member tested positive for Covid-19. The pharmacist said that he would inform the pharmacy's head office.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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 used effective questioning techniques to establish whether the medicines were suitable for the person and referred to the pharmacist where needed.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He had recently undertaken training about infection prevention and control, and about medicines which looked alike or their names sounded alike. He had also completed some risk management training. A training folder was kept to show which training had been completed, and this included some certificates issued by external training providers. Team members had access to online training modules, but they did not have time during the day to complete ongoing training. The trainee members of the team were concentrating on completing their training courses, but had to complete most of this in their own time due to the increased workload during the pandemic. The pharmacy received pharmacy-related magazines and information about medicines from suppliers. The pharmacist shared important information with team members. The pharmacist felt able to take professional decisions and targets were not currently set for team members. He said that he provided the services for the benefit of people using the pharmacy.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The trainee dispenser said that he often asked the pharmacist or other trained team members for help if he was unsure about any of the content of his course work. The team member had ongoing informal appraisals and performance reviews and they discussed any dispensing mistakes.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And 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. And this presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and intervened when needed. The pharmacy did not have any air conditioning units but the room temperature on the day of the inspection was suitable for storing medicines. The pharmacist explained that the windows at the front of the pharmacy had been partially covered to limit the amount of sunshine coming into the pharmacy. And this had helped a little to keep the room temperature down. He also said that the front and rear doors to the pharmacy could be kept open to allow airflow through the pharmacy. He would monitor the temperature in the warmer months and request a portable air-conditioning unit from the pharmacy’s head office if needed.

There was a large shop area and ample space for people to maintain a suitable distance from each other while accessing the services. There were marks on the floor to help people with distancing. There was a clear view into the pharmacy from outside so people could see how many people were in the shop area.

The pharmacy's main 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. Conversations at a normal level of volume 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. It gets its medicines from reputable suppliers and 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. People with a range of needs can access the pharmacy's services and the pharmacy highlights prescriptions for higher-risk medicines, so that there is an opportunity to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic 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 consultation room was sometimes used by a chiropodist. The pharmacist said that people were offered a free consultation and he sometimes referred people with diabetes to get checked.

The pharmacist said that he highlighted prescriptions for higher-risk medicines such as methotrexate and warfarin. He said that there were very few people who received warfarin from the pharmacy, as many had been swapped to a different medicine. He spoke with people about their medicines to ensure that they were taking them properly and checked people's monitoring record books when these were available. Patients taking valproate medicines were provided with warning cards and patient information leaflets. 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.

Stock was stored in an organised manner in the dispensary. The pharmacy had made changes and improved the date-checking routine since the last inspection. Expiry dates were now checked every three months and this activity was recorded. Items due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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 the pharmacy asked for prescriptions for alternate medicines 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 regularly and removed from the collection area after around three months. But there were several bags of dispensed medicines where the prescription was no longer valid. Several bags did not have a prescription or dispensing token attached. This may mean that there is a higher chance that medicines could be handed out when the prescription was no longer valid. The pharmacist said that he would review the system to help minimise the chance of this happening. The pharmacy did not highlight prescriptions for Schedule 3 and 4 CDs. The pharmacist said that these would be highlighted in the future to help team members identify prescriptions which were only valid for 28 days.

People's GPs carried out assessments for those who asked to have their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the 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. People contacted the pharmacy if they needed these medicines 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. There was an audit trail to show who had dispensed and checked each pack. And the medication descriptions were put on the packs to help people and their carers identify the medicines. Patient information leaflets were routinely supplied and backing sheets with information about the medicines were attached to the packs, but the additional warnings were not printed on the sheets. The pharmacist explained that the pharmacy had produced the backing sheets and these were not from the patient's medication record (PMR) on the computer. He said that he would contact the software provider and use the backing sheets from the PMR in future to ensure that all the relevant information was printed on them.

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, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The driver checked people's details while maintaining a suitable distance, and they wore personal protective equipment (PPE). 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. And the pharmacist 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. And it uses the equipment to help protect people's personal information.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring liquids was available and these were clean. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. The phone in the dispensary was portable so it could be taken to a more private area where needed.

The pharmacy had PPE available, including masks and hand sanitiser. One of the team wore a visor while at work, while others chose to wear masks when social distancing was not possible.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded on the computer. 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.