General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Carrs Pharmacy, 94 Calverley Road, TUNBRIDGE WELLS, Kent, TN1 2UN

Pharmacy reference: 1032991

Type of pharmacy: Community

Date of inspection: 29/08/2019

Pharmacy context

The pharmacy is located on a parade of shops close to a busy high street which is surrounded by residential premises. And is part of a large chain of pharmacies. The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service, travel vaccinations and antimalarials, emergency hormonal contraception, influenza vaccination (seasonal) and a minor ailments scheme. It supplies medication 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 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	N/A	N/A	N/A
2. Staff	Good practice	2.2	Good practice	Team members are given time set aside to undertake regular and structured training. This helps them keep their knowledge and skills up to date.
		2.4	Good practice	The pharmacy has a good culture of learning. It promotes learning, continuous improvement and the personal development of its team members.
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. It uses this information to help make its services safer and reduce any future risk. It mostly protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

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. Team members had signed the SOPs to indicate that these had been read and understood.

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 any patterns. The pharmacy's head office reviewed mistakes for the whole organisation so that learning could be shared between different pharmacies. Medicines in similar packaging or with similar names were separated where possible or the shelves were highlighted. 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 pharmacy technician (accuracy checking technician (ACT)) explained that the person was given the correct medicine and they were satisfied with the way the pharmacy had dealt with the incident. The medicines were separated on the shelf and the incident was shared with 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. The ACT knew which prescriptions she was allowed to check and said that this was detailed in the checking SOP. She explained that the pharmacist initialled prescriptions which had been clinically checked and she initialled them once she had carried out the accuracy check.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would open if the pharmacist had not turned up and the pharmacy's head office would be informed. She explained that she would not sell pharmacy-only medicines or hand out dispensed items before they had arrived but she thought that she could sell general sales list medicines. The inspector reminded the trainee dispenser what they could and shouldn't do if the pharmacist had not turned up. The trainee dispenser said that she would never be left working alone so would always have someone to ask if she was unsure. The trained dispenser knew that team members should not carry out any dispensing tasks if there was no responsible pharmacist (RP).

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. The emergency supply record was completed correctly and there were signed in-date Patient

Group Directions for the services. All necessary information was recorded when a supply of an unlicensed medicine was made. There were several private prescriptions that did not have the required information on them when the supply was made. And the prescriber's details were not always recorded in the private prescription record. The pharmacist said that she would remind team members to check the validity of private prescriptions before dispensing. And ensure that all the information was correct in the record. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not always recorded. The pharmacist said that she would ensure that this was recorded in future. The CD running balances were checked frequently and liquid 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 responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed.

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. Dispensed items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive with 98% of respondents satisfied with the staff overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy's practice leaflet. The medicines counter assistant (MCA) explained that she would offer people the use of the consultation room and inform the pharmacist if they wanted to make a complaint. The ACT said that there had been a recent complaint received where someone had complained about a possible breach of their confidentiality. The pharmacy had informed their head office and all team members had been reminded about maintaining confidentiality when speaking with people.

The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy’s head office. Some had also completed training about children’s oral health and dementia training. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that she had reported a safeguarding concern to the pharmacy’s head office and she spoke with an agency that dealt with safeguarding children. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough trained team members to provide its services safely. The team discusses adverse incidents and uses these to learn and improve. Team members are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions. 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 ACT, one trained dispenser, one trainee dispenser, one trained MCA and one trainee MCA working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. Trainee members of the team had been enrolled on accredited courses and the pharmacist said that the trainee MCA was due to be enrolled on a course once she had been working at the pharmacy for three months. 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 trainee MCA appeared confident when speaking with people. She said that she would refer to the pharmacist before selling any pharmacy-only medicine. She explained 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 were provided with ongoing training on a regular basis and they could complete this at work. Online training was provided by the pharmacy's head office and certificates were issued for completed modules. Training was checked by the pharmacy manager. Each member of the team had a training log which was kept up to date by the pharmacy manager. The pharmacy's head office encouraged team members to attend training events provided by external organisations. Team members who attended these events would receive travel allowance and two hours additional pay. The ACT had recently completed the CPPE risk management training. Team members had completed training about children's oral health, dementia and information governance. The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacist and ACT were aware of the Continuing Professional Development (CPD) requirement for the professional revalidation process. The ACT said that she was a dispenser accuracy checker before being registered as a pharmacy technician. She explained that she had checked with her accuracy checker course provider to ensure that she did not have to do any additional training before being allowed to work as an ACT.

All team members had yearly appraisals and performance reviews. The ACT said that she felt comfortable about discussing any issues with the pharmacist. There were informal huddles when important information needed to be passed on to team members. Team members discussed the information in the newsletters and any updates from the pharmacy's head office, including information

about the EU Falsified Medicines Directive (FMD). They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacy manager attended a yearly meeting at the pharmacy's head office where changes in legislation and company policies were discussed. The ACT said that she was due to attend a meeting for the pharmacy technicians from within the organisation. She said that she would have her travel reimbursed and food would be provided.

Targets were set for Medicines Use Reviews (MUR). The pharmacist said that she did not feel under pressure to achieve the targets and said that she would be supported by head office. She said that she would not let targets affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises 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 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 four chairs in the shop area. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Some items in the room had not been properly secured. The pharmacist locked the door and said that she would ensure that the room was kept secured when not in use in future. 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 manages its services well and provides them safely. 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. 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. Inside the pharmacy there was a set of steps leading up to the shop area. A lift was available for people who might not be able to use the stairs and this was in good working order. 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 were available. A 'Know your numbers' campaign was organised for a week in September where the pharmacy would offer free blood pressure checks for people.

The pharmacist said that a person had been experiencing difficulties with their breathing and had a low blood pressure. She explained that she had offered to call an ambulance for the person but they said that they did not want one. The pharmacist gave them some glucose and allowed them to use the consultation room until their symptoms subsided and they were able to leave the pharmacy. She said that she offered to call a taxi for them and suggested that they see their GP.

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 unless it was checked during an MUR. 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 highlighted and the date the prescription was due to expire was recorded at the top of the prescription. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. The pharmacist 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 pharmacy had the relevant patient information leaflets and up-to-date warning cards available. The ACT said that these would be supplied to people when needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Short dated stock lists were kept and items were removed from dispensing stock around one month before they were due to expire. The pharmacy had a wholesale dealer's license, but they did not wholesale CDs or fridge items.

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 ACT said that uncollected prescriptions were checked around every two months. Prescriptions left uncollected after around three months were returned to the NHS electronic system or kept at the pharmacy so that they could be re-dispensed if the person came to collect their medicines. Uncollected items were returned to dispensing stock where possible. The pharmacy received a weekly list of electronic prescriptions which had not been claimed so that the pharmacy could action these before the prescription had expired.

Prescriptions for people receiving their medicines in multi-compartment 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 ACT said that people contacted the pharmacy when they needed them. 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. This could increase the chance of them being misplaced. The ACT said that she would ensure that these were attached in future. Detailed medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. The ACT said that she was in the process of training some of the newer team members so that they could assemble the packs. She explained that she checked the medicines against the prescription before allowing team members to put them in the packs. This helped to minimise the chance of errors. A room upstairs in the pharmacy was used to assemble the packs. The ACT said that this helped to minimise distractions which meant that there were fewer mistakes.

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. This included returned Schedule 3 and 4 (part 1) CDs which needed to be denatured before disposal.

Deliveries were made by delivery drivers. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's address was protected. But their names were visible when people signed the back of the sheets. This was highlighted to a member of the team during the inspection. 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. A list of 'items out for delivery' was kept at the pharmacy so the people could be informed if they wanted to know when their medicines were due for delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. 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 FMD and it was being fully used. The team had been fully trained on the process and the pharmacy had an SOP.

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. Separate liquid measures were 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.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for less than two years and this would be replaced when needed. 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 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.