General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rusthall Pharmacy, 2 High Street, Rusthall, TUNBRIDGE WELLS, Kent, TN4 8RN

Pharmacy reference: 1032998

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

The pharmacy is located on a high street in a village in a largely residential area. It receives around 80% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews, the New Medicine Service and 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	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 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. Team members know how to protect people's personal information and they understand their role in protecting vulnerable people. People can provide feedback about the pharmacy's services, and this is used to improve the pharmacy's services. The pharmacy largely keeps the records it needs to by law.

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. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Alert stickers were used to highlight where certain medicines which 'looked alike or sounded alike were kept. Dispensing incidents where the product had been supplied to a person were recorded on a designated online 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 incident had been reported to the pharmacy's head office and the correct medicine had been supplied to the person.

Workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. There was an organised workflow which helped staff to prioritise tasks and manage the workload. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. Multi-compartment compliance packs were now assembled in a small room at the rear of the dispensary. This was a little larger than the room that was previously used. The area co-ordinator explained that there were plans to refit the store room so that there would be additional dispensing space in there.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would open if the pharmacist had not turned up. She knew that she should not carry out any dispensing tasks, sell any medicines or hand out any dispensed items until the pharmacist was in the pharmacy. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines if the pharmacist had left the pharmacy, but she was not sure if she could or hand out dispensed items or not. The inspector reminded her what she could and couldn't do 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. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made. And the emergency supply records were completed correctly. Controlled drug (CD) registers

examined were largely filled in correctly, but the address of the supplier was not usually recorded. The CD running balances were checked at regular intervals and liquid overage was recorded in the register. 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 correct 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.

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. And the pharmacy had made improvements since the previous inspection to ensure that this information was not visible from outside the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results showed that 90% of respondents had rated the staff as 'very good' overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that had been some complaints received about the time taken to dispense prescriptions after people had requested them from their surgery. The area co-ordinator visited the local surgery and discussed the issue with the practice manager and prescribers. He said that people were now allowing the pharmacy more time to dispense their medicines before going to the pharmacy to collect them.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some other team members explained that they had not completed any safeguarding training at the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser 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 trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training 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. The team discusses adverse incidents and uses these to learn and improve.

Inspector's evidence

There was pharmacist, one trained dispenser and one trainee MCA working at the start of the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. The trainee MCA said that she had worked at the pharmacy for just under three months. The pharmacist said that she would contact the pharmacy's head office to ensure that she was enrolled on an accredited course within the required timeframe. The pharmacist explained that she was covering at the pharmacy until a permanent manager was employed. The area co-ordinator arrived at the pharmacy during the inspection. He said that he was providing cover in the dispensary due to team members being on leave. Prior to him arriving at the pharmacy, the pharmacist had made him aware that the pharmacy was undergoing an inspection, and he arranged for additional cover for the day from another pharmacy technician. 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 was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members used effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members undertook online training modules provided by the pharmacy's head office and they received Counter Excellence booklets. The dispenser said that she had recently completed an accuracy checker course. She was waiting for confirmation that she could work as a checker. Team members did not currently have time during the working day to complete training. The pharmacist and pharmacy technicians were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist explained that she had recently completed CPD about the influenza vaccinations, sepsis, risk management, safeguarding and 'look alike and sound alike' medicines. The pharmacy's head office occasionally arranged training events and team members were provided with additional pay and travel allowances if they attended. Team members planned to attend an upcoming event about menopause.

The pharmacist said that she felt able to take professional decisions. She had completed declarations of competence and consultation skills some additional services, as well as associated training. But the pharmacy did not currently offer these additional services. The pharmacist had only worked at the pharmacy for a few days and she said that she would check with the pharmacy's head office before offering these services. Team members felt comfortable about discussing any issues with the

pharmacist or making any suggestions. Team members said that they had regular meetings to discuss ongoing issues and they had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist said that targets were not set for team members. She said that she carried out the services for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises largely 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 premises were secured from unauthorised access. Some areas of the pharmacy were not always kept locked, but there were usually team members present in these areas at the time. The pharmacist said that these areas would be kept locked in the future if there was not a team members present in them. The pharmacy was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter, but some of them were accessible to the side of the counter. Team members said that they had previously moved them so that they could not be reached by people using the pharmacy. The pharmacist said that she would ensure that a notice was displayed to show that these medicines were not for self-selection. Air conditioning was not available, although the room temperature was suitable for storing medicines on the day of the inspection. The dispenser said that the room temperature was warm during the summer months and she confirmed that she would monitor it in the future.

There were two chairs in the shop area. These were directly in front of the medicines counter. The trainee MCA said that she would offer the use of the consultation room if a person wanted to speak in a more private area. The consultation room was located in the shop area. It was small but it was accessible to wheelchair users, and it was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. The room was kept secured when not in use. Toilet facilities and kitchen areas 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 and people with a range of needs can access the pharmacy's services. The pharmacy 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. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use.

Inspector's evidence

There were two steps up 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 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 highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to reduce the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispenser said that team members checked CDs and fridge items with people when handing them out. 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 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. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock.

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. Uncollected prescriptions were checked regularly. Items uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or disposed of appropriately in the pharmacy.

The dispenser explained that some people had had assessments carried out by the pharmacy and others had them carried out by their GP, 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 largely suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the cautionary and advisory warnings were not printed on the backing sheets. The area co-ordinator contacted the pharmacy's head office during the inspection and he was able to change the settings so that these were printed on the backing sheets. He showed the dispenser how to change the settings. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This made it easier for people to identify their medicines and for them to have up-to-date information about how to take their medicines safely.

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 largely recorded in a register and destroyed with a witness; two signatures had been recorded when some had been destroyed.

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 information was protected. 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. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive and it was being used. Team members had undertaken training on how the system worked and there were written procedures available.

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 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. 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 shredder was 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.