General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bellegrove Pharmacy, 225 Bellegrove Road, WELLING, Kent, DA16 3RQ

Pharmacy reference: 1033014

Type of pharmacy: Community

Date of inspection: 22/02/2023

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. It provides a range of services, including the New Medicine Service, flu vaccinations, blood pressure checks and Strep A testing and treatment. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy 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. It receives most of its prescriptions electronically.

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 has a clear workflow, and the team members keep its dispensary workspace free from clutter. Team members understand their own roles and responsibilities. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and team members had signed them to show that they had read and understood them. The pharmacist informed team members if they had made a dispensing mistake which was identified during the dispensing process (near miss). Team members were responsible for identifying and rectifying their own mistakes were possible. The pharmacy had not recorded any near misses for around a year and the pharmacist accepted that there had been some during this time. He said that he would ensure that near misses were recorded in future and would be reviewed for patterns. 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, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that there had not been any recent dispensing errors.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Team members used baskets to help minimise the risk of medicines being transferred to a different prescription. And they initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy technician knew which tasks could not be undertaken if there was no responsible pharmacist (RP). And she knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any 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 nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. The pharmacist said that he would revert to the paper copy to ensure that it was completed correctly. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But the locum pharmacists did not always complete the record when they finished their shift.

Team members had completed training about protecting people's personal information. 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 electronic services were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints. The pharmacist had received a Commendation Award from the Mayor of Bexley for his services to the community during the pandemic. The pharmacy had recently started asking for patient feedback which had stopped at the start of the pandemic.

Team members had completed training about protecting vulnerable people. One of the dispensers described 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. And 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 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. The pharmacy has regular team meetings and team members can raise concerns to do with the pharmacy.

Inspector's evidence

There was one pharmacist, one pharmacy technician, two trainee pharmacists, one trained dispenser, one trainee dispenser and one trainee medicines counter assistant (MCA) working during the inspection. Team members were up to date with their workload and were communicating effectively with each other. They wore uniforms with name badges, which helped people using the pharmacy to identify them.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing medicines. And she said that she would refer to the pharmacist if a person regularly requested to purchase certain medicines which could be abused. She asked people questions to establish whether an over-the-counter medicine was suitable for the person it was intended for.

One of the trainee pharmacists explained the support she received from the pharmacist and said that she was provided with protected training time each week to ensure that she was able to keep up with her studies. The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacy technician had recently undertaken some ‘mother and baby’ training. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. And team members had access to online training modules. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to take professional decisions.

The pharmacist said that there were regular informal team meetings to discuss any work-related issues and allocate tasks to ensure the workload was well managed. He said that team members discuss new services to ensure that they knew their role in providing them. The pharmacist said that team members had yearly formal appraisals and performance reviews as well as ongoing informal reviews. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The pharmacist said that the services were provided for the benefit of the people using the pharmacy.

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 which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter. The pharmacist could hear conversations at the counter and could intervene when needed.

There were two chairs in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users and was in the shop area to the side of the medicines counter. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and there were hand washing facilities available. The toilet area was used to store some waste medicines for disposal and dispensed multi-compartment compliance packs. And this made it harder for the pharmacy to show that these medicines were being stored appropriately. The pharmacist said that he would ensure that medicines were not kept in the toilet area in future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It takes appropriate action in response to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. And it gets its medicines from reputable suppliers and stores them properly. It keeps its medicines which require cold storage in appropriate conditions. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he 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. The pharmacist said that the surgery would only issue prescriptions for people if they had an up-to-date blood test result. 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 he would ensure that this was done in future. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And he had ensured that people who were in the at-risk group were on the Pregnancy Prevention Programme if needed. The pharmacy had the relevant patient information leaflets and warning cards available. But it did not have the warning stickers for use with split packs. The pharmacist said that he would order these from the medicine manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked frequently and items due to expire within the next couple of months were disposed of appropriately. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. 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. And denaturing kits were available for the safe destruction of CDs.

The pharmacist said that uncollected prescriptions were checked monthly and item uncollected after around two months were removed from the retrieval system. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently and people were given an 'owing' note if their prescription could not be dispensed in full. People were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy technician explained that the pharmacy would also contact the other branches in the company to try and source medicines for people.

The pharmacist said that he would speak with people who he thought might benefit from having their medicines in multi-compartment compliance packs. And he would refer them to their GP for an assessment to be undertaken. 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. And prescriptions for 'when required' medicines were not routinely requested. The dispenser said that people requested prescriptions for these 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 kept any hospital discharge letters for future reference. The dispenser wore gloves when handling medicines that were placed in these packs. Packs were suitably labelled but the backing sheets were not attached to the packs which could increase the chance of them being misplaced. The dispenser said that these would be attached in future. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. But the cautionary and advisory warning labels were not recorded on the backing sheets. This could make it more difficult for people to know how to take their medicines safely. The pharmacist said that he would ensure that these were added in future.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. If the delivery was returned to the pharmacy, 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. The pharmacist explained the action the pharmacy took in response to any alerts or recalls received from the NHS or the MHRA. Any action taken was recorded and kept for future reference which made 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. 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 used to measure marked for certain medicines 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 blood pressure monitor was replaced in line with manufacturer’s guidance. The weighing scales and the shredders were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.