General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: 7 Day Chemist, 175 Bellegrove Road, WELLING, Kent, DA16 3QS

Pharmacy reference: 1033016

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

The pharmacy is located on a busy high street in a town centre surrounded by residential premises. And is open seven days a week. It provides a range of services including multi-compartment compliance aids to a few people living in their own homes.

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 generally identifies and manages the risks associated with its services. But team members are not all aware of which tasks should not be completed if the pharmacist is not there. This could mean that tasks are undertaken without suitable supervision. The pharmacy 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 generally protects people's personal information. Team members understand their role in protecting vulnerable people.

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; the pharmacy technician said that mistakes were pointed out by the pharmacist. There were only a few near misses recorded on the log since February 2019. There was no evidence that the log was reviewed for trends and patterns. Cardboard dividers were used to separate medicines in similar packaging.

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 dispenser had contacted the person following the incident to ensure that they had not taken any. The person had not wanted to pursue the matter further as no harm had been caused.

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 did not sign the dispensing label when they dispensed and checked each item to show who had completed these tasks. The lack of a complete audit trail to show those involved in dispensing each item means that opportunities to learn from mistakes may be missed.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy technician thought that she could sell general sales list medicines and carry out dispensing tasks if the pharmacist had not turned up. The trainee medicines counter assistant (MCA) said that she would not sell pharmacy only medicines or hand out bagged items if the pharmacist was not on the premises. During the inspection the pharmacist temporarily left the premises to open the back gate as the rear door was blocked from the outside. The trainee MCA had to be reminded not to sell any pharmacy only medicines while the pharmacist was not in the pharmacy.

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 not recorded when a supply of an unlicensed special was made. The prescriber details and patient's address were not routinely recorded in the private prescription record. The pharmacy had dispensed several hospital prescriptions on which the patient's or prescriber's address was not recorded. 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 around once every three months. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The address of the supplier was not routinely recorded in the CD registers. The correct responsible pharmacist (RP) notice was clearly displayed. The RP had completed the RP log in advance of finishing his shift. There were two days recently where there was no RP recorded in the log. The pharmacist said that the pharmacy was open on those two days (7 and 21 April 2019). The pharmacist said that he would ensure that all records were kept up to date.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Some bagged items waiting collection were kept on the floor and on shelves behind the medicines counter. Some of the prescriptions were facing the shop area. So, people's information was potentially visible to people using the pharmacy. This was highlighted to the pharmacist during the inspection. And he agreed to ensure that people's personal information was not facing the shop area.

The pharmacy carried out yearly patient satisfaction surveys; results were on the NHS website. Recent results showed that 95% of respondents rated the services as good, very good or excellent. Areas for improvement included to improve waiting times for walk-in patients and stock availability. The pharmacist said that there had not been any recent complaints. A complaints procedure was available for team members to follow where needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. The pharmacy technician could not recall having done any safeguarding training. She 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 pharmacist recalled a safeguarding concern that happened around six months ago where he had to refer a person to the police.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They can raise any concerns or make suggestions. The team members can take professional decisions to ensure people taking medicines are safe. But they are not always provided with ongoing structured training. This may mean that they are missing opportunities to keep their skills and knowledge up to date.

Inspector's evidence

There was one pharmacist, one dispenser and one trainee MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The trainee MCA was not enrolled on an approved pharmacy course at the start of the inspection and she had been working at the pharmacy for over three months. The pharmacist arranged for her to be enrolled on a course the same day.

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. Effective questioning techniques were used to establish whether the medicines were suitable for the person. The trainee MCA referred to the pharmacist throughout the inspection.

The pharmacy technician said that she had completed all entries required for her continuing professional development and revalidation. She said that she completed regular training including counter skills booklets. She did not usually work at this pharmacy and was covering for a dispenser who was on planned leave.

The pharmacist said that the pharmacy did not hold regular meetings. He said that the pharmacy regularly received emails from the superintendent pharmacist. The pharmacy technician said that she had had a performance review and an appraisal around four years ago. But nothing since. She said that she felt confident to discuss any issues with the pharmacists. The pharmacist said that targets were not set. He said that Medicines Use Reviews were carried out for the benefit of the people using the pharmacy.

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. Air-conditioning was available; the room temperature was suitable for storing medicines. There were two chairs in the shop area for people to use. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Open delivery boxes were left in the shop area. These contained medicines which should not be accessible to people using the pharmacy. There was little room in the dispensary to keep these boxes while unpacking the orders. The pharmacist said that he would ensure that these boxes were kept in the consultation room while being unpacked.

The consultation room was in the process of being fitted out. The pharmacist said that the room had recently been built. The door was not kept locked during the inspection. Some prescription only medicines were kept in the room. The pharmacist said that he would ensure that the room was kept locked. And he confirmed in an email that this had been done.

Toilet facilities were in a large building to the rear of the pharmacy. The building was also used to store excess medicines. There were separate hand washing facilities available. But these were not clean. The pharmacist said that a cleaner was employed, and he would ensure that she cleaned the toilet area during her next visit.

The sink in the dispensary was partially blocked and there was a pool of water in it which was slow to drain. The pharmacist said that he had attempted to get it resolved in the past. But, this was not possible as there was an ongoing issue with the plumbing in the building.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well. But it does not always give people additional information that comes with their medicines. This could mean that they may not have all the information they need to take them safely. The pharmacy gets its medicines from reputable suppliers. And generally stores them safely and manages them well. But it 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 a small step up to the pharmacy. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The pharmacist said that there was one person who used a wheelchair. He said that they knocked on the door and were provided with assistance. A variety of patient information leaflets were available in the shop area. Services and opening times were clearly advertised.

The pharmacist said that he checked monitoring record books for people taking high risk medicines such as methotrexate and warfarin. But a record of results was not kept. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for these medicines were not highlighted so there is potential that the opportunity to speak with these people is missed. Prescriptions for schedule 3 and 4 CDs were not highlighted. The trainee MCA thought that all prescriptions were valid for two months. She was not aware of the 28 day validity for schedule 4 CDs. There was a prescription for a schedule 4 CD waiting collection which had expired around a month ago. The pharmacist said that he would highlight prescriptions for higher risk medicines. The pharmacist said that dispensed fridge items were shown to people when handing out. He said that the pharmacy supplied valproate medicines to a few patients who may become pregnant. But it did not have the patient information leaflets or 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 eight months was marked. The pharmacist said that items were removed from dispensing stock around one month before they were due to expire. There were several mixed batches found in with dispensing stock.

The pharmacist said that part dispensed prescriptions were checked daily. 'Owings' notes were provided, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until items were collected. There were several prescriptions which had expired with some dated in 2017. The pharmacist said that uncollected prescriptions were checked monthly. He said that items uncollected after around two months were returned to dispensing stock where possible. Prescriptions were kept until no longer valid so that these could be re-dispensed if the person came to collect.

Prescriptions for people receiving their medicines in compliance aids 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 pharmacist said that people routinely contacted the

pharmacy when they needed these medicines. The pharmacy had started to keep records patients which included any changes to their medication. Compliance aids were suitably labelled but the backing sheets were not attached to the compliance aids. This could increase the chance of them being misplaced. There was an audit trail to show who had dispensed and checked each compliance aid. Medication descriptions were put on the compliance aids. But the pharmacist said that patient information leaflets (PILs) were not routinely supplied.

CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs 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.

Deliveries were usually made by a delivery driver. But the delivery driver had recently left the pharmacy. The pharmacist said that the pharmacy did not obtain people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered.

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 via email; the pharmacist said that these were printed, and any action taken was kept for future reference.

The pharmacy had the equipment installed ready for the implementation of the EU Falsified Medicines Directive. The pharmacy technician said that she had not received any training in preparation for using the equipment.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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. There was only one measure available and this had a thick layer of lime scale around the top and black bits inside. The pharmacist said that he would ensure that this was cleaned, or another measure ordered. An electronic counter was available and clean; a separate counter was marked for cytotoxic use only.

The phone in the dispensary was portable so could be taken to a more private area where needed. The shredder was in good working order. 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.