General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swalecliffe Pharmacy, 5-7 St. Johns Road, Swalecliffe, WHITSTABLE, Kent, CT5 2QT

Pharmacy reference: 1033025

Type of pharmacy: Community

Date of inspection: 02/11/2021

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 95% of its prescriptions electronically. And it provides a range of services, including the New Medicine Service, stop smoking service, diabetes checks, flu vaccinations. It also supplies PCR test kits to people. 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. 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. The pharmacy largely protects people's personal information. It records any mistakes that happen during the dispensing process. And it keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members generally understand their role in protecting vulnerable people, but some of them may benefit from some additional training about safeguarding.

Inspector's evidence

The pharmacy had carried out workplace risk assessments in relation to Covid-19. And it adopted adequate measures for identifying and managing risks associated with its activities. There were up-to-date standard operating procedures (SOPs) available and team members had read these. Near misses, where a dispensing mistake was 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 on individual trackers, but the trainee dispenser said that she had not had her tracker 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. The trainee dispenser said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. She said that these would be dealt with by the superintendent pharmacist (who was not at the pharmacy during the inspection).

Workspace in the dispensary was largely free from clutter. There was a large number of items waiting to be checked by the pharmacist. These were organised in baskets to help minimise the risk of medicines being transferred to a different prescription. And an organised workflow helped staff to prioritise tasks and manage the workload. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that team members could access the pharmacy if the pharmacist had not turned up. The team were a little unclear about the tasks which could be carried out without there being a responsible pharmacist (RP). But they knew which tasks could not be carried out if the RP was not in the pharmacy. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. 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 CD running balances were checked at regular intervals. The right RP notice was clearly displayed, and the RP record was completed correctly. The private prescription records and emergency supply records could not be located during the inspection. The trainee dispenser thought that these were locked in the office. The trainee dispenser explained that a nature of emergency was recorded if a prescription was not expected following the supply, but if the medicine was 'loaned' against an expected prescription then the nature of emergency was not recorded. This could make it harder for the pharmacy to find these details if there was a future query. Following the inspection, the inspector spoke with the superintendent pharmacist (SI) who explained that the private prescription records and records of emergency supplies were on the pharmacy's

electronic patient medication system. He said that he would ensure that team members knew how to access this information.

Bagged items waiting collection could not be viewed by people using the pharmacy. 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 overnight in the pharmacy. Several team members did not have their own smartcards and were using ones belonging to other people. One of the cards belonged to someone who was not working at the pharmacy on the day of the inspection. The trainee dispenser thought that cards had been requested, but she had worked at the pharmacy for around one year and had not received one yet. She said that she would speak with the SI, and in the meantime team members would not share cards or personal identification numbers for them.

The pharmacy had carried not carried out a recent patient satisfaction surveys, due to the ongoing pandemic. The complaints procedure was available for team members to follow if needed. The trainee dispenser said that she would refer any complaints to the pharmacist on duty or to the SI.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispensers said that they had not undertaken any safeguarding training, but they would refer any concerns to the pharmacist. A safeguarding SOP was available for team members to follow, but this did not mention potential signs that might indicate a safeguarding concern. The trainee dispenser said they 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 training to help maintain their knowledge. Team members can take professional decisions to ensure people taking medicines are safe. And they can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one locum pharmacist, one trained dispenser, four trainee dispensers and one trained medicines counter assistant (MCA) working during the inspection. Some team members had completed an accredited course for their role and the rest were undertaking training. There was one member of the team who was not present during the inspection who had worked at the pharmacy for around two or three months. The inspector discussed with one of the trainee dispensers, the training requirements and that team members must be enrolled on a suitable course within three months of starting work at the pharmacy. Team members worked well together during the inspection and they communicated effectively with each other to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacist about the reporting process if a team member tested positive for the coronavirus.

The 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 were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to take professional decisions while at work in the pharmacy. He said that he had recently undertaken some research about the government guidelines on over prescribing and the role of the pharmacist. The pharmacist said that he had not been set any targets for any of the services.

Team members felt comfortable about discussing any issues with the pharmacist. The trainee dispenser said that he had received two appraisals since starting at the pharmacy around one year ago. But he was not sure if these had been documented. The pharmacy did not hold any regular meetings. Information was passed on informally during the day.

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 and this presented a professional image. Pharmacy-only medicines were mostly kept behind the counter, but some could be accessed to the side of the counter by people using the pharmacy. The inspector discussed this with the team during the inspection and they said that the medicines would be rearranged so that pharmacy-only medicines could only be selected by staff. 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, and the room temperature was suitable for storing medicines. Extendable barriers were used to restrict access behind the medicines counter.

There were clear screens at the medicines counter to help minimise the spread of infection. Floor markings were used to help people maintain a suitable distance from each other and there was a one-way system in the shop area. There were several chairs in the shop area. These were positioned away from the main counter area to help minimise the risk of conversations being heard. And the chairs were set at suitable distances from each other to help people maintain social distancing.

The pharmacy's main consultation room was accessible to wheelchair users and was in the shop area. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room was suitably equipped, and well-screened, but it was not always kept secure when not in use. The ‘in-use’ sharps bin was kept on the floor and it was accessible to people using the consultation room. And some other items were not kept secure in the room. This was discussed with the pharmacist during the inspection. He said that the room was usually kept locked when not in use and he would remind team members.

Toilet facilities were clean and not used for storing pharmacy items and 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. 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. 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 wide entrance into the pharmacy with double automatic sliding doors. There was one step up to the pharmacy 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. Large print labels were available, and the pharmacy could print additional information on paper which could easily be referenced to the relevant box of medicine using a numbered system.

Prescriptions for higher-risk medicines were not routinely highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And this could also make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 2 and 3 CDs were routinely highlighted but prescriptions for Schedule 4 CDs weren't. The MCA was not sure how long these prescriptions were valid for and this could increase the chance of these medicines being supplied when the prescription is no longer valid. The inspector discussed with the team about highlighting prescriptions for higher-risk medicines and Schedule 4 CDs. Dispensed fridge items were kept separate from other items in the fridge and were not placed into bags to aid identification. The dispensers said that they did not check CDs and fridge items with people when handing them out. The inspector discussed with them the reasons why it might be helpful to check these types of medicines with people and they said that this was something they will probably do in the future. The trainee dispenser said that the pharmacy supplied valproate medicines to a few people. But he did not know if there were any who needed to be on the Pregnancy Prevention Programme. Warning cards were attached to the medicine packaging, but the trainee dispensers were not aware that these must be supplied to all females taking this medicine every time it was supplied. The trainee dispenser could not find any relevant patient information leaflets or additional warning cards or warning stickers. She said that she would request these from the manufacturer. And she would ensure that the stickers were used and the warning cards supplied where needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Stock due to expire within the next few months were marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked twice a day. '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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The dispenser said that uncollected prescriptions were checked regularly. Prescriptions uncollected after a

few months were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. There were a few prescriptions for Schedule 2 CDs in the retrieval system which were no longer valid. The pharmacist said that these would have been rechecked for their validity by him and the items would not have been handed out.

The pharmacist was not sure if people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs to show that they needed them. But he said that he would refer people to their GP if they requested to have their medicines in these 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. The dispenser said that people would contact the pharmacy 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 suitably labelled and there was an audit trail to show who had dispensed and checked each pack. 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 have up-to-date information about how to take their medicines safely. The packs were dispensed in a large room to the rear of the dispensary, and this helped to minimise distractions and allowed more space for dispensing.

CDs were stored in suitable cabinets which were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were kept in different cabinet from the dispensing stock. Returned CDs were recorded in a register but there were several recent entries where the only signature belonged to a healthcare assistant. There were several entries on older paperwork which suggested that there was some returned CDs which had not been destroyed. These records were from 2017 to 2019, but the medicines could not be found in the cabinet. The trainee dispenser said that she would speak with the SI about this.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The delivery driver working on the day of the inspection explained how he carried out the deliveries to ensure that he maintained a suitable distance from people. The pharmacy kept a copy of the delivery sheet for reference, so that people could be informed whether their medicine was out for delivery if they contacted the pharmacy. 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 delivery driver passed any messages to a member of the dispensary team when he returned to the pharmacy. And he handed over any undelivered medicines and prescriptions collected from the surgeries.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. 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. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Tablet counters were available and clean, and 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 phone in the dispensary was portable so it could be taken to a more private area where needed. Personal protective equipment such as masks, gloves and hand gel were available. Team members wore masks while at work.

The fridges were suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. The temperatures were within the range at the time of the inspection. But records indicated that the temperatures had sometimes gone outside the recommended range. The trainee dispenser explained how a reset was carried out and that the temperatures were rechecked following this. But any follow up action taken, or subsequent temperatures were not recorded. She said that she would ensure that these were recorded in the future.

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.