General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tankerton Pharmacy, 99 Tankerton Road, Tankerton, WHITSTABLE, Kent, CT5 2AJ

Pharmacy reference: 1033027

Type of pharmacy: Community

Date of inspection: 03/08/2022

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service, stop smoking, flu vaccinations and Covid-19 vaccinations. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some 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 learns from mistakes that happen during the dispensing process to help make its services safer. People using the pharmacy can provide feedback about its services. And team members know what to do to help protect vulnerable people. The pharmacy largely protects people's personal information. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

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), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. 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. One of the dispensers explained how the pharmacist would allow them time to identify their own mistakes and then they would have to rectify them. 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 a recent change had been made so that medicines with two active ingredients combined, were kept separated from medicines with only one active ingredient to help minimise the chance of the wrong medicine being selected. The outcomes from the reviews were discussed with all team members. 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 he was not aware of any dispensing errors at the pharmacy since he started working at the pharmacy for around one year.

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 initialled 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. One of the dispensers explained that a notice would be displayed in the pharmacy's window if the pharmacist had not turned up in the morning. She said that dispensed items would not be handed out and she would not sell any pharmacy-only medicines. But she thought that she could sell medicines on the general sales list. Team members knew which tasks should not be carried out if the responsible pharmacist (RP) was not in the pharmacy.

The right RP notice was clearly displayed and the RP record was completed correctly. And the pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals with any liquid overage 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 completed correctly. But the nature of the emergency was not always recorded when a supply of a prescription-

only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that he would ensure that this information was recorded in future.

Confidential waste was shredded at the pharmacy, computers were password protected and people using the pharmacy could not see information on the computer screens. Team members used their own smartcards during the inspection to access the NHS spine these were stored securely when the pharmacy was closed. Team members had completed training about protecting people's personal information. People's personal information on the bagged items waiting collection were not visible from the shop area. But it was potentially visible to people when accessing the consultation room to the rear of the pharmacy. The inspector discussed potential solutions with the pharmacist during the inspection, and the pharmacist provided assurances that the issue would be addressed promptly following the inspection.

The pharmacy had carried out yearly patient satisfaction surveys, but it had not carried one out since the start of the pandemic. The complaints procedure was available for team members to follow if needed and team members would direct any complaints to the pharmacist. The pharmacist said that there had not been any complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. The pharmacist said that there had not been any recent safeguarding concerns at the pharmacy. And 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 are provided with some training to help keep their knowledge up to date. They can raise any concerns or make suggestions to help improve the pharmacy's services and systems. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (who was the owner), two trained dispensers and two trainee dispensers working at the start of the inspection. The trainee dispensers finished their shift at lunch time, and another trainee dispenser worked in the afternoon. The pharmacist was aware of the timeframe to enrol new team members on approved courses for their role. One of the trainee dispensers was in the process of reading the SOPs and she explained that once she had understood the processes, she signed the SOPs. And she said that she had been shadowing other team members to ensure that she fully understood the processes. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people. They were aware of the restrictions on sales of medicines containing pseudoephedrine and they knew the reason. One of the dispensers explained that she would refer to the pharmacist if a person were regularly requesting to purchase medicines which could be abused or may require additional care. And she explained the questions she would ask to establish whether the medicines were suitable for the person.

One of the dispensers explained that she had completed some training modules provided to the pharmacy from an external training provider before the pandemic. But she has not undertaken any regular ongoing training since the start of the pandemic. She was a stop smoking adviser and explained that she kept her up to date with her knowledge by learning about new products. Trained team members said that they would be allowed time during the working day to undertake training modules, but most preferred to complete these in their own time at home.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He said that he had learned about different vitamins and minerals and this was due to some people asking about some of the products sold in the pharmacy. The pharmacist felt able to take professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. Vitamins and minerals, due to people asking questions about the products sold in the pharmacy.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They had ongoing informal appraisals carried out. And team members said that the pharmacist regularly let them know when they were performing well and they occasionally received something as a reward. The team did not have regular meetings, but team members explained that the pharmacist would pass on important information where needed. Targets were not set for team members. The pharmacist said that the pharmacy provided its services for the benefit of the people who used 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. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. There was air conditioning available and the room temperature was suitable for storing medicines.

There were two consultation rooms in the pharmacy. The consultation room in the shop area was mostly used for providing the Covid vaccination service. It was accessible to wheelchair users and it was suitably equipped. The pharmacist explained that the second consultation room would be used if additional privacy was needed as people could not be seen from the shop area. Conversations at a normal level of volume in the consultation rooms could not be heard from the shop area. There were three chairs in the shop area for people to use. 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 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 largely stores them properly. It responds appropriately to drug alerts and product recalls which helps make sure that its medicines and devices are safe for people to use. The pharmacy dispenses medicines into multi-compartment compliance packs safely. But it 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. 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 pharmacy had been providing the Covid vaccination service and the pharmacist had completed all the necessary training for this. The pharmacy had administered the vaccine to a small number of people recently as the demand for the service had reduced significantly.

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. 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. Prescriptions for Schedule 3 CDs were highlighted, but those for Schedule 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 Schedule 4 CDs were also highlighted. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispensers said they 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. But it did not have the relevant patient information leaflets, or warning stickers available. The pharmacist said that these would be ordered from the medicine manufacturer.

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. And lists of short-dated items were kept. The pharmacy had not removed medicines which had expired in July 2022. Having expired items with dispensing stock increases the risk of these medicines being supplied to people. Team members said that these would be removed promptly following the inspection.

Part-dispensed prescriptions were checked frequently. '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 pharmacist said that uncollected prescriptions were checked regularly, and people were called if they had not collected their medicines after around two months. Prescriptions for uncollected items were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance 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 and one of the dispensers said that people ordered them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and it 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. Team members wore gloves when handling medicines that were placed in these packs.

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, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The pharmacist said that he would be starting to get signatures in the near future. The inspector discussed with him ways in which the pharmacy could maintain patient confidentiality while people signed for their medicines. 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 which 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. Separate liquid measures were used to measure marked for use with certain liquids. 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 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 and 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.