

# Registered pharmacy inspection report

**Pharmacy Name:** Conneyhall Pharmacy, 5 Coneyhall Parade,  
Kingsway, WEST WICKHAM, Kent, BR4 9JB

**Pharmacy reference:** 1033041

**Type of pharmacy:** Community

**Date of inspection:** 31/10/2019

## Pharmacy context

This is a community pharmacy in a parade of shops in the town of West Wickham. The surrounding area is largely residential, and there are several local doctor's surgeries. The pharmacy provides some services under patient group directions (PGDs) such as seasonal flu vaccinations and emergency hormonal contraception. It supplies medication in multi-compartment compliance packs to residents in care homes and people in their homes who need help managing their medicines.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** Improvement Action Plan

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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. Team members can show how they learn from any dispensing mistakes to make the pharmacy's services safer. And they know how to protect vulnerable people. People who use the pharmacy are asked for their feedback so that the pharmacy can learn and improve. The pharmacy generally protects people's personal information properly. But it could do more to ensure that confidential waste is always disposed of appropriately.

### Inspector's evidence

Near misses were recorded on a sheet in the dispensary, but there had been a recent gap where only two had been recorded since August. The pharmacist accepted that some had not been recorded, but that they usually did so and would ensure they were recorded in the future. He gave an example of a near miss that had occurred between esomeprazole and escitalopram and showed that the medicines had been separated on the shelves to help prevent a recurrence. Dispensing errors were recorded on the computer system, and a recent error had been recorded where two different medicines with similar names had been mixed up. The pharmacist said that he had discussed the incident with the team in a team meeting and showed how the medicines had since been highlighted on the shelves.

A range of standard operating procedures (SOPs) was present. They were in-date, and the individual procedures were well indexed. Team members had read and signed the SOPs relevant to their role. Team members described what they could and couldn't do if the pharmacist had not turned up for work, but some thought that they could sell General Sales List medicines. The inspector reminded them of the requirements.

The pharmacy undertook an annual patient survey. The results from the recent survey were on the NHS website and they were positive, with 100% of respondents rating the pharmacy as very good or excellent overall. Team members were familiar with the complaint procedure. People could find out how to make a complaint or provide feedback from the practice leaflet.

The pharmacy had a current indemnity insurance certificate. The responsible pharmacist (RP) notice was clearly displayed so that people knew who the current RP was. The RP log was largely maintained in accordance with requirements. Private prescription records and records of unlicensed medicines had been completed correctly. Most emergency supply records seen complied with requirements, but a few did not indicate the full reason as to the nature of the emergency. This could make it harder for the pharmacy to find out those details if there was a future query. Controlled drug (CD) registers examined were generally in order, and the CD running balances were checked routinely.

No confidential information was visible to people using the pharmacy. A shredder was available to destroy confidential waste, but some items containing people's personal details were found in general waste. These were immediately removed and shredded, and the team members said that they would be vigilant and ensure confidential waste was disposed of appropriately in the future. There was an information governance policy, but it was from before 2018 and details inside it had not been filled in. The pharmacist said that he would review the policy and ensure that team members were familiar with it. Computer terminals were password protected and the screens were turned away from people using

the pharmacy. The dispenser didn't have an NHS smartcard and the pharmacist had put a smartcard in which belonged to another dispenser who was on holiday. The pharmacist had his own smartcard and said he would use this in the future and organise smartcards for the other team members.

Team members had read and signed the pharmacy's safeguarding procedure, and the dispenser said that she had watched a video on safeguarding. The pharmacist confirmed that he had completed the level 2 safeguarding training and he described what he would do if he had any concerns about a vulnerable person. The dispenser gave an example of a safeguarding concern she had had, and it had been referred to the local GP surgery.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to provide its services safely. They get the right training for their roles. And they get ongoing training to help keep their knowledge and skills up to date. They feel comfortable about making suggestions or raising any concerns to help improve the pharmacy's services. And they can take professional decisions so that people are kept safe.

### Inspector's evidence

At the time of the inspection there was one pharmacist (who was also the superintendent pharmacist), two trainee dispensers, and one trained medicines counter assistant (MCA). The pharmacist also employed another MCA who had worked at the pharmacy for almost three months; the pharmacist said that they would be registered on an accredited course the day after the inspection. Staff were observed communicating well with each other, and the trainee dispensers had a comprehensive handover discussion when changing shifts. Team members were managing their workload well, and dispensing was up to date.

The MCA and trainee dispenser described how they went to external training sessions, which were usually held in the evening. They also received training on any new products and discussed any incidents if they arose. They were sometimes given time to complete the ongoing training in work, but this was usually not the case. The pharmacist was aware of the professional revalidation process to ensure that his own knowledge and skills were kept up to date.

Team members felt comfortable about raising any concerns or making suggestions. They did not have regular meetings, but as it was a small team they discussed any issues as they needed to. The pharmacy did not have numerical targets, and the pharmacist felt able to take any professional decisions.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises are suitable for the pharmacy's services and they are kept secure from unauthorised access. People can have a conversation with a team member in a private area.

### Inspector's evidence

The pharmacy was clean and mostly tidy, and lighting was good throughout. There was ample clear workspace to allow team members to dispense safely. One worktop faced the shop area and it was covered in paperwork and untidy; this detracted somewhat from the otherwise professional appearance of the pharmacy. The pharmacist said that he would tidy it.

The consultation room was small, but it was clean and tidy. There were some items inside which were not secured properly, and the pharmacist said that he would keep the room locked when not in use and ensure people were not left in there alone. The room allowed a conversation to take place inside which would not be overheard.

The room temperature was suitable for the storage of medicines and was maintained with air conditioning. The premises were kept secure from unauthorised access. Team members had access to handwashing facilities.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy provides its services safely and manages them adequately. It obtains its stock from reputable sources and generally stores it properly. It takes the right action in response to safety alerts, so people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services. But the pharmacy doesn't highlight prescriptions for higher-risk medicines. This could mean that it misses out on opportunities to speak to people when they collect these medicines.

### Inspector's evidence

The pharmacy had a small, steep ramp from street level. The pharmacist said that people with wheelchairs or mobility aids were able to use it to access the pharmacy, and if needed, team members went out to assist people. A list of the services the pharmacy provided was in the practice leaflet. The pharmacy's opening times were displayed in the window.

There was a clear workflow through the dispensary and there was ample clear workspace. Baskets were sometimes used when dispensing to help prevent mixing up people's medicines, but the staff said that they only used this with large or bulky items. The amount of workspace allowed a good separation distance between any prescriptions being dispensed.

Prescriptions were not always kept with dispensed medicines, and this could make it harder for the team member handing it out to know if the prescription was still valid. Prescriptions for higher-risk items such as warfarin or methotrexate were not routinely highlighted. A bag of dispensed medicines on the shelf was found to contain warfarin, and this had not been highlighted to alert the person handing it out. This could mean that opportunities to speak with people collecting these medicines are missed. The pharmacist said that the prescriptions for higher-risk medicines would be highlighted in the future. The pharmacist said that the pharmacy highlighted prescriptions for CDs as they had a shorter validity date, but no examples of dispensed CDs were found on the shelves.

The pharmacist was aware of the updated guidance about pregnancy prevention for valproate medicines. He confirmed that the pharmacy did not have any people taking valproate who were in the at-risk group. The relevant educational literature such as cards and leaflets could not be located during the inspection and the pharmacist said that he would order more in if necessary.

The pharmacy had the equipment and software to comply with the Falsified Medicines Directive but it was not fully in use. The pharmacist said that the pharmacy would start using it routinely once he had received more guidance from the suppliers.

The pharmacist explained how the pharmacy maintained an audit trail of medicines delivered to people's homes. The book containing the records was with the driver during the inspection and was not available. The pharmacist said that recipients signed an address label in a book, and he would review the system to ensure that other people's personal information was protected.

There was an audit trail in place for each step of the process for when multi-compartment compliance packs were dispensed. This included when the prescription had been ordered, dispensed, and

medicines delivered. The pharmacy supplied to people in their own homes and to care home residents. The trainee dispenser showed how she kept a record of any changes in people's medicines or when there was communication with their prescriber. And she kept a record of who had dispensed and checked the packs. Patient information leaflets were routinely supplied to people with the packs, but the labels on the packs did not contain the cautionary and advisory warnings. The pharmacist said that he would check with the pharmacy's software provider to resolve this. People were assessed for the compliance pack service by the local Bromley Medicines Optimisation Service. The service also checked with people six weeks after starting the packs to see how they were managing with them.

Signed, in-date PGDs were available for the flu vaccination service and the pharmacist described the training he had undertaken for all PGD services provided. The signed PGD for the emergency hormonal contraception service could not be found, but the pharmacist showed the associated paperwork from 2019 and explained that he was signed up for the service with the local NHS commissioning group.

The pharmacy obtained its medicines from licenced wholesaler dealers and specials suppliers. And it stored its stock in a tidy and orderly manner in the dispensary. CDs were stored securely. Medicines that needed cold storage were kept in a medical fridge. The temperatures were monitored daily and the previous records seen were in range.

Stock was date checked regularly, but one expired medicine was found. Two boxes of medicines contained mixed batches; this could mean that date checks or product recalls can be dealt with less effectively. Bulk liquids were not all marked with the date of opening, which made it harder for team members to know if the medicine was still suitable to use. The pharmacist said that he would discuss these issues with the team and ensure that they were addressed.

The pharmacy received drug alerts and recalls and the pharmacist described the action the team took in response. He was aware of recent recalls. But a record of the action taken was not recorded, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep these records in the future.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for its services. It maintains them well and uses its equipment in a way which protects people's personal information.

### Inspector's evidence

A range of calibrated glass measures was available, and they were clean. Team members had access to up-to-date reference sources and the internet. Adrenaline pens were available for when vaccinations were done. Tablet counting triangles were clean, and a separate marked one was used for cytotoxic medicines to avoid cross-contamination.

The phone was cordless and could be moved to a more private area of the pharmacy to help protect people's personal information. The fax machine was out of sight of people using the pharmacy.

### 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.