General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Westchem Pharmacy, 89 Station Road, WEST WICKHAM, Kent, BR4 0PX

Pharmacy reference: 1033046

Type of pharmacy: Community

Date of inspection: 24/07/2019

Pharmacy context

This is a community pharmacy in a town centre with residential areas nearby. It is opposite a supermarket. A range of people use the pharmacy, and a large proportion of them are older. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines, mainly to people from the local area.

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 well. It largely keeps the records it needs to by law to ensure that medicines are supplied safely and legally. Team members generally protect people's personal information well. And they know how to protect vulnerable people. They know about their own roles and responsibilities. But the standard operating procedures are overdue for review. This could mean that they do not reflect current best practice.

Inspector's evidence

A range of standard operating procedures (SOPs) was present. They had a range of review dates on them, and most were overdue for review. The pharmacist said that he was aware of this and would ensure that they were all reviewed in the near future. Team members had signed most of the SOPs to indicate that they had read and understood them, but some were unsigned. For example, the SOP around selling pseudoephedrine over the counter was unsigned, although the medicines counter assistant (MCA) was able to explain how many packs she could sell. The pharmacist said that he would go through the SOPs with the team members to make sure that they were aware of the ones relevant to their roles.

The pharmacy did not employ dispensers, and the pharmacists were responsible for both dispensing and checking medicines. The pharmacist was observed not to take any mental break between the two processes. This was discussed during the inspection and the pharmacist said that he would review his dispensing and checking process.

A system was in place to record near misses, but no recent records were found. The pharmacist said that the dispensing volume was low, and he was unable to think of any examples of near misses that had occurred recently. He said that he would ensure that if any occurred in the future he would record them. Dispensing errors were recorded on a standardised form. The pharmacist said that one had occurred the day before inspection and he would write it up and identify any improvements that could be made. He showed how he had separated medicines which sounded or looked alike, such as zolmitriptan and olanzapine, and atorvastatin and losartan. This helped reduce the change of a picking mistake happening.

The pharmacist said that they carried out two audits every year. A recent one had been on children's oral health, and he said that as a result they had identified that some parents were not aware of the need for toothpaste for babies. He explained that they were able to provide this information to people, and he had noticed more people asking for further information on the subject.

The MCA was able to describe what she could and couldn't do if the pharmacist had not turned up, and she explained the additional care she took when selling a medicine that could be abused.

There was information on the NHS complaints procedure in the SOPs, but team members had not signed it. The pharmacist was not aware of any recent complaints. The pharmacy did an annual patient questionnaire, and the results from the latest one were positive with 100% of respondents rating the pharmacy as very good or excellent overall. There was no information such as signs or leaflets to explain to people how they could provide feedback. Copies of these were found in the SOP folder and

the pharmacist said he would put some on display.

The pharmacy had a current indemnity insurance certificate displayed. The responsible pharmacist (RP) log had been filled in correctly and the right RP notice was displayed. Records for private prescriptions, emergency supplies, and specials complied with requirements. The controlled drug (CD) registers examined had been filled in satisfactorily. The CD running balance checks varied in frequency. Although most of them were checked when stock was obtained or dispensed, some slower moving lines had not received a balance check for up to two years. The pharmacist said that he would check them on a more regular basis in the future.

People's personal information was generally protected, and none could be seen from the shop area. The consultation room was behind the dispensary, and people walking to it went past a shelving rack which contained some people's personal information. The pharmacist explained that they very rarely used the room, and that if he needed to use it in the future he would ensure that this information was protected properly. Computer screens were turned away from people using the pharmacy, and the pharmacist had his own smartcard to access the electronic NHS systems. He said that the information governance policy was off site as it was being updated and he would bring it back to the pharmacy soon. A shredder was used to dispose of confidential waste.

The pharmacist confirmed that he had completed the level 2 safeguarding training and could explain what he would do if he had any concerns. He showed an NHS safeguarding app on his phone which contained useful information and contact details. The MCA could describe the possible signs of abuse and said that she would refer any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough trained team members for the pharmacy's services. They are provided with some ongoing training to help keep their knowledge and skills up to date. They can raise concerns and make suggestions to help improve the pharmacy's services.

Inspector's evidence

At the time of the inspection there was a pharmacist (pharmacy owner) and a trained MCA. The pharmacist confirmed that the other MCA the pharmacy employed had also completed the required accredited course. Another pharmacist covered for the owner's days off. Dispensing was generally up to date and the team was managing its workload well. The pharmacist felt able to take professional decisions to help ensure that people were safe.

Team members did not do regular ongoing training, but the pharmacist explained that he gave them training modules that came in from suppliers and manufacturers. The MCA said that she went through these and was usually able to complete them in work time. She said that she had recently completed a training pack about sun protection and allergies.

The MCA felt comfortable about raising any concerns or making suggestions to the pharmacist. The owner often worked at the pharmacy and was easily contactable. There was a small team in the pharmacy, and the MCA said that they discussed any issues as they arose. Staff did not have any targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and largely suitable for the pharmacy's services. People can have a conversation with a pharmacist in a private area.

Inspector's evidence

The pharmacy was generally clean and tidy, with an adequate amount of clear workspace for dispensing. Lighting was good throughout. The consultation room was behind the dispensary (see also Principle 1 above) and allowed a conversation to take place inside which would not be overheard.

There was a seating area in the shop where people could wait to have their prescriptions dispensed. The pharmacy was seen to be relatively quiet during the inspection, with normally one person coming in at a time. The room temperature was suitable for the storage of medicines and was maintained with air conditioning. Handwashing facilities were available. The pharmacy was secured from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services in a safe and effective manner. It generally manages its medicines well and takes the right action in response to safety alerts. This helps ensure that people get medicines which are safe to use. But, the pharmacist doesn't always highlight prescriptions for higher-risk medicines. And this could mean that opportunities are missed to provide people with all the information they need to take their medicines safely.

Inspector's evidence

There was a small step at the front of the pharmacy. The pharmacist explained that they could see people waiting outside and would go and assist them into the pharmacy. The pharmacy had wide aisles to help people with mobility aids or pushchairs to manoeuvre. There was a range of leaflets to help people access information about local services and medical conditions.

Dispensing baskets were available, but the pharmacist said that he didn't use them often and his practice was to dispense one prescription at a time to help avoid people's medicines becoming mixed up. He was following this practice during the inspection.

The pharmacist was aware of the additional guidance about pregnancy prevention to be given to some people taking valproate. He said that the pharmacy had one person in the at-risk group and he had discussed this with them. There was the additional safety literature available for valproate, such as cards, leaflets, and stickers. The pharmacist explained how he counselled people who were supplied higher-risk medicines. He said that in the case of methotrexate, he explained it was a weekly dose, and that they should attend regular blood tests. The prescriptions for higher-risk medicines were not highlighted, but the pharmacist explained that he usually handed them out to people himself and counselled them as appropriate. The MCA was also involved in handing out dispensed medicines. One dispensed medicine bag containing methotrexate was found on the shelf; this had not been highlighted so the person handing out would not know to speak with the pharmacist. The pharmacist said that he would highlight these prescriptions with 'see pharmacist' in the future. Prescriptions for Schedule 3 and 4 CDs were not routinely highlighted, and the MCA was unsure how long they were valid for. The pharmacist said that the system they used for these CDs would be reviewed to help prevent them being handed out when the prescription had expired.

The pharmacy provided medicines in multi-compartment compliance packs to two people. No packs were available to be examined during the inspection. The pharmacist said that they supplied patient information leaflets regularly. He was unsure how they would document any conversations with the prescriber or changes in the packs but said that he would record this on the electronic patient medication record in the future. He said that the pharmacy was not intending to increase the number of people receiving the compliance pack service.

Medicines were obtained from licenced wholesale dealers and specials suppliers and were stored in an orderly manner in the dispensary. Medicines were date checked regularly and this was supported with records. However, one date-expired medicine was found in with stock; this was removed for destruction. Medicines for destruction were segregated from stock and placed into designated bins and sacks for secure offsite disposal. CDs were stored securely. Medicines requiring cold storage were

stored appropriately in a fridge. The fridge temperatures were usually recorded daily, but this had not been done for the last two or three days. The current minimum and maximum temperatures were within the required range, and the pharmacist said that they would be recorded daily in the future. Previous records were also within the required range.

The pharmacist explained that he had the equipment to comply with the Falsified Medicines Directive (FMD) but had not yet subscribed to the service as he was unsure what was happening with the FMD in the future. The requirements were discussed with the pharmacist during the inspection.

The pharmacist said that he had signed up for the MHRA email alert system and explained that he received recalls and safety alerts via email. Most of them were seen to have been printed out and a record made of the action taken, but the recent one for paracetamol had not been printed. The pharmacist said that he had received the recall and had checked the stock and had found no affected batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment it needs for its services. It uses some of this equipment to help protect people's personal information.

Inspector's evidence

Two calibrated glass measures were available, but they could not accurately measure quantities of less than five millilitres. The pharmacist said that he would order another in. Tablet counting triangles were clean. The pharmacy had access to up-to-date reference sources. The fax machine was away from the public area. The pharmacist explained that they had a second phone line with a cordless phone, and they moved the phone somewhere more private to protect people's personal information.

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.