General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Delmergate, 38 Broomfield Road, Hunters Forstal, HERNE BAY, Kent, CT6 7LY

Pharmacy reference: 1082813

Type of pharmacy: Community

Date of inspection: 05/09/2024

Pharmacy context

The pharmacy is next to a surgery in a largely residential area near the seaside town of Herne Bay. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and blood pressure checks. And it uses patient group directions for the contraception and travel vaccination services.

Overall inspection outcome

Standards not all 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
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	There are not always enough team members to ensure that the pharmacy is up to date with its workload.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy cannot show that its medicines requiring refrigeration are stored appropriately.
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 to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. And team members' roles and responsibilities were specified in the SOPs. Team members knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And they knew that they should not sell any pharmacy-only medicines if the pharmacist was not in the pharmacy. They explained that the pharmacy would remain closed if the pharmacist had not turned up in the morning.

Team members explained that the pharmacist informed them about dispensing mistakes which were identified before the medicine had been handed out (also known as near misses). And they were responsible for identifying and rectifying their own near misses. The pharmacy recorded near misses, and it reviewed them regularly for any patterns. And the outcomes from the reviews were discussed openly with the team. The pharmacy separated items in similar packaging or with similar names where possible to help minimise the chance of the wrong medicine being selected. And following a recent review of the near miss record, the pharmacy had moved bisoprolol tablets to lower shelves so that they were now at eye level. Team members said that this had reduced the number of times the wrong strength of this medicine had been selected. The pharmacist explained that the pharmacy undertook a root cause analysis and made a record of dispensing mistakes that had been handed out (also known as dispensing errors). And the pharmacy's head office was informed. Team members said that they were not aware of any recent dispensing errors.

There was an organised workflow which helped staff to prioritise tasks and workspace in the dispensary was free from clutter. Team members used baskets to help minimise the risk of medicines being transferred to a different prescription during the dispensing process. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacist initialled prescriptions to show that he had clinically checked it. The dispenser accuracy checker knew that they she should not check medicines if she had been involved in dispensing them. And there were certain medicines that she should not check.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. And the private prescription records were completed correctly. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The pharmacist said that people were usually referred to NHS 111 if they needed an emergency supply. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Team members had completed training about protecting people's personal information. Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens. Team members used their own smartcards to access the NHS spine during the inspection. And they explained how these were secured when not in use. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

Team members said that they would attempt to deal with any complaints in the pharmacy and they would inform the pharmacy's head office. They said that if a person had complained directly to the pharmacy's head office, it would inform the team so that they could investigate the complaint. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Team members said that there had not been any recent complaints.

Team members had completed training about protecting vulnerable people. They described potential signs that might indicate a safeguarding concern and explained that they would refer any concerns to the pharmacist. Team members said that there had not been any safeguarding concerns at the pharmacy. But they knew where to find the contact details available for agencies who dealt with safeguarding vulnerable people. And a team member said that could contact the safeguarding lead at the pharmacy's head office if needed.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always ensure that it had enough team members to manage its workload. Team members do the right training for their roles, and they can raise any concerns. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one dispenser accuracy checker (NVQ level 3 student) and six trained dispensers working during the inspection. The accuracy checker (who was also the non-pharmacist branch lead) explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. She explained that her role as the branch lead included managing staff holidays, sickness, and enduring admin tasks such as the CD balance checks were undertaken. Team members communicated effectively during the inspection to ensure that tasks were prioritised. Team members explained that the pharmacy was around five days behind with its dispensing. And this meant that people had to sometimes wait around 30 minutes for their medicines to be dispensed. The accuracy checker said there had been some recent staffing issues which had contributed to this, but that the pharmacy should be fully staffed again soon. Following the inspection, the inspector spoke with the superintendent pharmacist who provided assurances that he would review the staffing levels at the pharmacy and assistance would be provided if needed.

Team members appeared confident when speaking with people. The person working in the medicines counter during the inspection knew which medicines could be misused or may require additional care. She said that she would speak with the pharmacist if a person regularly requested to purchase one of these medicines. And she was aware of the restrictions on sales of medicines containing pseudoephedrine containing products. She knew the types of questions to ask to establish whether an over-the-counter medicine was suitable for the person it was intended for.

Team members said that they were not provided with ongoing training on a regular basis, but they did receive some from the pharmacy's head office. And they could do the training at work during quieter times. The pharmacist was aware of the continuing professional development requirement for professional revalidation. She explained that she had recently completed training for the Pharmacy First service and urinary incontinence. And she regularly attended online workshops. She also mentioned that she had done some learning about prescriptions for transgender people. The pharmacist felt able to make professional decisions.

Team members said that they had informal morning huddles to ensure that tasks were allocated, and any issues were discussed. The branch manager said that the pharmacy received information from its head office via a newsletter and this was discussed with the team. Team members said that they had ongoing informal performance reviews. And they could discuss any issues with the pharmacist, branch manager or the pharmacy's head office. The branch lead explained that the pharmacy was part of a messaging group with other local pharmacies and surgeries. This allowed them to share information about services or stock issues.

Targets were set for the New Medicine Service and the Pharmacy First services. Team members said that the pharmacy felt under pressure to achieve the targets and it regularly struggled to meet them. But they would not let the targets affect their professional judgement. The pharmacist said that on many occasions she had undertaken a consultation for a service but the person was not eligible.

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 against unauthorised access and pharmacy-only medicines were kept behind the counter. 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. The pharmacy was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users, and it could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy gets its medicines from reputable suppliers, and it largely stores them properly. But it doesn't always store medicines requiring refrigeration within the appropriate temperature ranges. Overall, the pharmacy manages its other services appropriately. It responds appropriately to drug alerts and product recalls which helps make sure that its medicines and devices are safe for people to use. And people with a range of needs can access the pharmacy's services.

Inspector's evidence

Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access into the pharmacy through a wide entrance. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacy could produce large-print labels for people who needed them. And there was a shelf at the medicines counter at a suitable height for wheelchair users. The pharmacist said that she was not trained to provide all the enhanced NHS services. She explained that people would be signposted to a local pharmacy that offered them, or they were asked to return when the regular pharmacist was working.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 2 and 3 CDs were highlighted, but this was not done for Schedule 4 CDs. This could increase the chance of these medicines being supplied when the prescription was no longer valid. Team members said that they members 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 (PPP). The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging. The pharmacist and branch lead explained that the pharmacy provided patient information and warning cards to people taking topiramate. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines and blood test results might be missed. This was discussed with the team during the inspection.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The branch lead 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.

Stock was stored in an organised manner in the dispensary and short-dated items were highlighted. Expiry dates were checked every month and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacy stored medicines in three fridges which were not overstocked. The fridge in the

consultation room was pharmaceutical grade and the two fridges in the dispensary were of a domestic variety. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were not consistently within the recommended range for the two domestic fridges. A team member said that the issues with the fridges had been ongoing for a couple of months. The pharmacy's head office had been made aware and the pharmacy had received a replacement fridge. But two of them were still not maintaining the appropriate temperatures. There was ice found on the back wall of one of the fridges and a box of medicine was stuck to it. A team member said that the affected stock would be disposed of appropriately. The thermometer on the day of the inspection for that fridge was showing the following temperatures: maximum 9 degrees Celsius, current 4.3 degrees Celsius and minimum 1 degrees Celsius. Following the inspection, the superintendent pharmacist provided assurances that the fridges would be replaced.

Part-dispensed prescriptions were checked daily. '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. Uncollected prescriptions were checked regularly and item remaining uncollected after around two months were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber.

Deliveries were usually made by a delivery driver and one of the dispensers provided cover when needed. The pharmacy had a sheet available to record people's signatures for deliveries, but this was not currently being used. The layout of the sheet meant that people's personal information would be protected. Team members said that they would remind the delivery driver to obtain signatures in future. 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. A cool box was available when transporting fridge items.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its equipment to help protect people's personal information. And it largely has the equipment it needs to provide its services safely.

Inspector's evidence

Triangle tablet counters and suitable equipment for measuring liquids was available and clean. A separate counter was marked for cytotoxic use only which 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. The pharmacy had up-to-date reference sources. Team members said that the blood pressure monitor had been in use for less than one year and it would be replaced in line with the manufacturer's guidance by the pharmacy's head office. The weighing scales and carbon monoxide machine appeared to be in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.