

Registered pharmacy inspection report

Pharmacy Name: McArdle Pharmacy, 41 Canterbury Road,
FOLKESTONE, Kent, CT19 5NJ

Pharmacy reference: 1088498

Type of pharmacy: Community

Date of inspection: 29/10/2019

Pharmacy context

The pharmacy is located on a small parade of shops which is surrounded by residential premises. The pharmacy receives around 85% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, a stop smoking service, weight management service, influenza vaccinations and a travel clinic. It also does INR tests and supplies warfarin against prescriptions written by the pharmacist. It 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. 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It largely protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely. And team members understand their role in protecting vulnerable people.

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), near miss and dispensing incident reporting and review processes. Team members had signed to show that they had read and understood the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. 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. Shelf edges where medicines which 'look alike and sound alike' were kept were highlighted to help minimise the chance of a selection error. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The shelves where these medicines were kept were highlighted with the different strengths to help minimise the chance of a similar mistake. Risk assessments were carried out for the higher-risk services offered and for the pharmacy in general.

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 signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checking technician (ACT) explained which prescriptions she could carry out the final accuracy check for and the pharmacist signed the prescriptions which he had clinically checked. She knew that she should not check items if she had been involved with the dispensing of them.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. She knew that she should not hand out any dispensed items before the pharmacist had arrived, but she thought that she could sell some General Sales List medicines. The inspector reminded her what she could and shouldn't do if the pharmacist had not turned up. The ACT knew that team members should not carry out any dispensing tasks before the pharmacist had signed in as being responsible.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. And there were signed in-date Patient Group Directions available for the relevant services offered. 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. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals and at the time of dispensing. Methadone balances were checked frequently and any liquid overage was 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 correct RP notice was clearly displayed and the responsible pharmacist (RP) log was largely completed correctly. But, there were a few occasions when the RP had not completed the log when they had finished their shift. The pharmacist said that he would remind pharmacists to complete the log properly in the future.

Confidential waste was shredded and computers were password protected. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could be viewed by people using the pharmacy, and there were some people's personal information on the bags. The MCA turned these around during the inspection and the pharmacist said that he would ensure that these were not visible in the future.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop area and were available on the NHS website. Results were positive and 100% of respondents were satisfied with the pharmacy and the service they had received from team members. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The ACT said that she was not aware of any recent complaints.

The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy, including Dementia Friends training. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that 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. The team members can take professional decisions to ensure people taking medicines are safe. The team discusses adverse incidents and uses these to learn and improve. They are provided with some training to support their learning needs and maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one pharmacist, one ACT, two trained dispensers and one trained MCA working during the inspection. One of the dispensers usually worked at the other pharmacy within the organisation and was helping out on the day of the inspection due to staff shortages. The pharmacy was in the process of recruiting a dispenser. The MCA had worked at the pharmacy for around two months. She said that she was going to be enrolled on a dispensers course once her probation period was over. The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist and ACT were aware of the continuing professional development requirement for the professional revalidation process. The ACT explained about some CPPE training she had recently completed and that medicines representatives sometimes provided information about new products. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. The ACT said that she ensured that updates or product information was passed on to other team members. The pharmacist had recently completed some CPPE training about sepsis and risk assessments. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they received appraisals and performance reviews at regular intervals. The pharmacist said that the pharmacy had recently received prescriptions for medicines that might potentially interact with the warfarin that the person was taking. He explained that he contacted the person's surgery to inform them and both were changed to other more suitable medicines. The pharmacy kept records of interventions and communication with surgeries about people's medicines. The pharmacist had completed declarations of competence and consultation skills for the services offered, as well as associated training. Targets were not set for team members. The pharmacist explained that the services were provided for the benefit of the people using 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; this presented a professional image. 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. Air conditioning was available; the room temperature was suitable for storing medicines.

There were five chairs in the shop area. These were close to the medicines counter which meant that conversations at the counter could potentially be overheard. The MCA said that she would offer the use of the consultation room if someone wanted to have a more private conversation with a member of the team.

The consultation room was accessible to wheelchair users. It was located in the shop area and it was suitably equipped. Low-level conversations in the consultation room could not be heard from the shop area. But, the window in the door was see-through and the door was not lockable. This may pose a risk to privacy, particularly if a person removed an item of clothing. The pharmacist said that he would request that a lock be fitted and that the window would be obscured.

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. 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 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.

An appointment system was used for the INR and warfarin service. The pharmacist tested people's blood and recorded the test results on 'INR Star'. Prescriptions were written by the pharmacist and dispensed by another member of the team before being checked by the pharmacist. The pharmacist wore gloves when taking blood samples. Prescriptions for higher-risk medicines such as methotrexate were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The ACT said that she would ensure that these were highlighted in the future. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The MCA was confident on which medicines were Schedule 3 CDs and knew that the prescriptions for these had to be signed by the person collecting them. But, she was not sure which medicines were Schedule 4 CDs and did not know that prescriptions for these were only valid for 28 days. Dispensed fridge items were kept in clear plastic bags to aid identification. The ACT said they checked CDs and fridge items with people when handing them out. The ACT said the pharmacy supplied valproate medicines to a few people. And there was one person who was on the Pregnancy Prevention Programme. She confirmed that the person's carer had been made aware of the risks with taking the medicine. The pharmacy had the relevant patient information leaflets or warning cards available.

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 few months was marked. There were no date-expired items found in with dispensing stock.

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. The ACT that uncollected prescriptions were checked regularly and items 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. The pharmacy kept a record of any uncollected items so that people could be informed if they came to the pharmacy to collect their medicine.

The dispenser said that people receiving their medicines in multi-compartment compliance packs had assessments carried out by their GP to show that they needed the 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 contacted the pharmacy when they needed them with their packs. 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 largely labelled correctly and there was an audit trail to show who had dispensed and checked each pack. But the additional cautionary and advisory warnings were not on the backing sheets. The dispenser said that she would contact the software provider to request that these be added. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The dispenser said that she would ensure that these were supplied in the future.

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; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. The pharmacy kept list to show which items were 'out for delivery' so that people could be informed 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 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The ACT said that she had undertaken some training on how the system worked. She explained that the system would likely start to be used fully in the new year.

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 marked for methadone use only. An electronic tablet counter was available, but there was a thick layer of powder residue inside it. The ACT said that she would ensure that this was cleaned and she would encourage team members to use triangle tablet counters instead as these were easier to clean. 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 pharmacist said that the blood pressure monitor was calibrated at regular intervals. The carbon monoxide testing machine was calibrated by an outside agency. 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. The machine used to test people's INR was calibrated at regular intervals by sending samples to an external agency.

Fridge temperatures were checked daily; 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.