General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Horsmans Place, Instone Road, DARTFORD, Kent, DA1 2JP

Pharmacy reference: 1089881

Type of pharmacy: Community

Date of inspection: 21/08/2019

Pharmacy context

The pharmacy is located near to a large town centre and is surrounded by residential premises. The people who use the pharmacy are mainly older people. It usually receives around 95% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service. It supplies medications in multi-compartment compliance packs to large number of people who live in their own homes to help them take their medicines safely.

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 met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not have enough clear floor space to allow team members to work comfortably. The number of boxes stored in the dispensary presents a significant tripping hazard for team members.
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 largely identifies and manages the risks associated with its services. It protects people's personal information and it actively seeks feedback from the public. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members read the SOPs online and completed activities to show that they had understood the information.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. The pharmacist said that near misses were recorded onto the online system and reviewed regularly for any patterns. There were a couple of near misses that occurred during the inspection, but the pharmacist was not sure if these had been recorded as the computers were both in use at the time. She said that she would implement a paper copy and have an audit trail to show that these had been uploaded onto the electronic system. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong form of medicine had been supplied to a person. The person realised the mistake before taking the tablets and returned them to the pharmacy. And the correct medicine was supplied. The medicines were in very similar packaging and had been kept next to each other. The pharmacy did not stock one of the medicines at the time of the inspection. The pharmacist confirmed that if these were stocked in future then they would be kept separate from the other similar medicines.

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.

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would not open if the pharmacist had not turned up. She said that team members would not access the pharmacy until the pharmacist had arrived. She explained that she would not sell pharmacy only medicines or hand out dispensed items if the pharmacist was not on the premises.

The pharmacy had current professional indemnity and public liability insurance in place. 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 special was made. The private prescription was largely completed correctly, but the prescriber's address was not always recorded. One of the prescriptions found did not have the prescriber's address on. The pharmacist said that she would remind team members to ensure that prescriptions contained all the required information at the time of dispensing. The nature of the emergency was not routinely 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 she would remind team members to record this in future.

The pharmacist said that controlled drug (CD) running balances should be checked once a week, but this was not always done. There were some loose sheets in the registers. The pharmacist said that she would ensure that the registers were properly secured to help minimise the chance of these being lost. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct responsible pharmacist (RP) notice was clearly displayed and the RP log was largely completed, but there were alterations made to the RP record. And there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query.

Confidential waste was removed by a specialist waste contractor and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people in the shop area. But a person walked past the medicine counter and approached the dispensary counter to speak with a member of the team. There was no barrier in place to restrict access behind the counter and team members did not stop the person. This was discussed with the team during the inspection.

The pharmacy carried out yearly patient satisfaction surveys; results from a recent survey were displayed in the shop area and were available on the NHS website. The pharmacist said that the pharmacy had recently received complaints from people about the time taken to be served. She said that this had improved recently, and a new system was being put in place to help team members find dispensed items waiting collection. A hand-held device was in the process of being installed so that team members could search for a person's name and find out where in the dispensing process their prescription was.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Some of the other team members had completed training provided by the pharmacy's head office. The trainee dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that she was not aware of 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. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns and this means that they can help improve the systems in the pharmacy. The 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 were two pharmacists, three trained dispensers and one trainee dispenser working during the inspection. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The pharmacy had recently had staffing issues and two members of the team were on long term leave. Head office had responded by providing cover and team members had worked one day when the pharmacy was closed to help catch up with dispensing.

The trainee dispenser 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 trainee dispenser was enrolled on an accredited dispenser course and other team members had completed accredited courses for their roles. The pharmacist said that the previous pharmacy manager would have monitored staff training but she did not currently have the required computer access yet. She said that the area manager should be monitoring it. Team members said that they completed regular online training. The pharmacist said that she encouraged team members to complete the training in the pharmacy, but they also had access to the online training modules at home. She said that team members had regular performance reviews and appraisals.

The pharmacist said that information was passed on to team members informally and there were no formal meetings held. She said that as she had only worked at the pharmacy for around two weeks and she was in the process of implementing more formalised meetings. The trainee dispenser said that she felt that she could discuss any issues with the pharmacist during the working day. The pharmacy regularly received updates from head office highlighting any issues throughout the organisation and this information was on the pharmacy intranet.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that she did not feel under pressure to achieve the targets and would not let these affect her professional judgement. She said that the pharmacy was not currently hitting the targets due to the recent staffing issues.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises provide a secure and clean environment for the pharmacy's services. But there is limited floor space in the dispensary and there are significant tripping hazards for team members.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and generally tidy. Pharmacy-only medicines were kept behind the counter. 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. A large portable air-conditioning unit was available, but the room temperature on the day of the inspection felt warm. The unit was towards the rear of the dispensary and a fan was available towards the front of the dispensary. The fan was not in use and the dispenser said that it just blew hot air around. She said that the room temperature felt like it was above the recommended range during warmer days. The main entrance to the pharmacy was left open during the day. The pharmacist said that she would monitor the room temperature to provide assurance that the medicines were being stored appropriately.

Floor space in the pharmacy was limited and there were several boxes which were tripping hazards for team members. Team members struggled to pass each other in the dispensary and frequently touched each other when passing. The pharmacy supplied a large number of multi-compartment compliance packs, and this impacted on the work space available. The limited room in the dispensary meant that several delivery boxes were left in the shop area. The pharmacist moved these boxes into the dispensary during the inspection and this added to the lack of clear floor space.

There were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to the side of the medicines counter. It was suitably equipped and well-screened. Low level conversations in the consultation room could not be heard from the shop area. The room was small and on the day of the inspection it was not accessible to wheelchair users due to several boxes being stored outside the room. If a person in a wheelchair wanted to use the room, a chair would have to be removed. The room was warm even though there was a small fan in use.

Toilet facilities were available in the surgery. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely manages them well. The pharmacy gets its medicines from reputable suppliers and manages them appropriately to make sure that they are safe to use. It takes the right action in response to safety alerts. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. A variety of health information leaflets were available in the consultation room. Services and opening times were clearly advertised. The pharmacy was in the process of having a new computer system installed so most of the prescriptions were currently printed by the surgeries. This temporarily increased the time people waited for their prescriptions to be dispensed.

Prescriptions for higher-risk medicines were not always highlighted. So, the opportunity to speak with these people when they collected their medicines might be missed. The pharmacist said that she checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. And she made a record of results on their medication record. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The trainee dispenser knew that prescriptions for Schedule 3 CDs were valid for 28 days but she was unsure which medicines were classed as Schedule 4 CDs and was not sure how long these prescriptions were valid for. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But she was not aware of any people taking valproate who needed to be on a Pregnancy Prevention Programme. She could not locate the up-to-date patient information leaflets and warning cards. But said that she would order replacements from the manufacturer if needed.

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 a couple of date-expired items found in with dispensing stock. One had expired at the end of May 2019 and one in June 2019. The regional manager said that the pharmacy was in the process of getting the date checking up to date. Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were sometimes above the recommended range. On the day of the inspection the current temperature was within the recommended range, but the maximum temperature was 8.4 degrees Celsius. The pharmacist said that she had reset the thermometer after checking it in the morning and showed the inspector how she did this. The buttons she pressed did not reset the thermometer and it was still showing that the maximum was 8.4 degrees Celsius. The pharmacist said that she would contact the manufacturer of the fridge to find out how to reset the thermometer.

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. There was a prescription with an item owing on it but it was not signed and some medicines had been supplied against it. There were some dispensing labels attached to blank pieces of paper. The pharmacist said that the prescriptions had been filed and the medicines would not be dispensed. She said that she would annotate the piece of paper so that other team members knew not to dispense these. The trainee dispenser said that uncollected prescriptions were checked regularly and items uncollected after around four weeks were

returned to dispensing stock when possible. There were two prescriptions found waiting collection which had not been signed. The pharmacist said that she would remind team members to check that prescriptions had been signed before making a supply. She said that the prescriptions would be returned to the prescribers for signing.

Multi-compartment compliance packs were being dispensed by another pharmacy within the organisation and were returned to the pharmacy to be checked. The regional manager said that these should have been checked at the other pharmacy and be ready for delivery. He said that there were two pharmacists at the other pharmacy to cover the additional workload and he would confirm why they were not checking the trays. The pharmacy had received two weeks of dispensed trays due to the change in computer system. This was to try and ease the workload at the pharmacy, but the pharmacist's workload had not reduced. The pharmacy kept a record for each person which included any changes to their medication. They also kept hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had checked each pack, but there was no audit trail to show who had dispensed them. Medication descriptions were put on the packs and patient information leaflets were routinely supplied.

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; these were recorded in a way so that another person’s information could be protected. But one of the drivers was not folding the sheets before obtaining signatures. The pharmacist said that she would discuss this with the driver. If a 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 patient to contact the pharmacy to rearrange delivery.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from head office. Any action taken was kept showing what it had done in response.

The pharmacist thought that the pharmacy had the equipment ready for the implementation of the Falsified Medicines Directive (FMD), but team members did not know how to use it. They attempted to scan some 2D bar codes during the inspection but these were not recognised on the scanner they were using. The pharmacist said that the FMD was being managed centrally by their head office. The regional manager said that the pharmacy did not have the equipment installed but head office was in the process of addressing it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring liquids was available, but an oral syringe was being used to measure small amounts. The measures were not clean. The pharmacist said that these would be cleaned and replacements would be ordered. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. The phone in the dispensary was portable so 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.