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: 11/08/2020

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 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 small number of people who live in their own homes to help them take their medicines safely. The inspection was carried out during the Covid-19 pandemic.

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. It 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. The pharmacy largely protects people's personal information and people using the pharmacy can provide feedback or make a complaint.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with pharmacy activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members read the SOPs online and completed activities to show that they had understood the information. Workplace risk assessments in relation of COvid-19 had been carried out and a copy of these was kept at the pharmacy.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. The pharmacist said that near misses were recorded onto the online system and reviewed regularly for any patterns. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error 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. The correct medicine was then supplied. The medicines were in very similar packaging and had been kept next to each other. These were now kept separated to help minimise the chance of a similar mistake.

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 dispenser (pharmacy manager) said that the pharmacy would not open if the pharmacist had not turned up in the morning. 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. Records required for the safe provision of pharmacy services were available and all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription record was 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 controlled drug (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. The correct responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly.

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 and smartcards used to access the NHS spine were stored securely. Team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people in the shop area. There was a retractable barrier to restrict access behind the counter. The dispenser explained that people accessing the consultation room would have to walk past visible confidential information which they could potentially read. The pharmacist said that this had been highlighted as a potential issue and she would discuss it with the pharmacy's head office before making any changes.

The pharmacy carried out yearly patient satisfaction surveys; results from the most recent survey were available on the NHS website. But the dispenser said that she was not aware of any surveys having been carried out this year. The pharmacist said that the pharmacy had not received any complaints recently. A hand-held device was now in use so that team members could search for a person's name and find out where in the dispensing process their prescription was. This had helped to reduce the time taken for people to receive their medicines.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser had completed training provided by the pharmacy's head office. She could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had been some concerns about a vulnerable person and the pharmacy had contacted the person's GP. 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 was one pharmacist and one dispenser working during the inspection. The dispenser was also that pharmacy manager. The team members wore 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 dispenser said that one team member had been furloughed and another had recently left and neither had been replaced. She explained that the part-time dispenser was allowed to work some additional hours to help manage the workload. The dispenser said that the pharmacy would contact one of the regional managers to ask for additional cover if a member of the team was absent for sickness reasons. Team members wore face coverings, regularly washed their hands and used hand gel to help minimise the risk of contracting or spreading the coronavirus.

The 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.

Team members had completed accredited courses for their roles. The dispenser said that she ensured that team members completed any necessary training, but she did not currently have the required computer access yet to monitor it properly. She said that training was usually completed online and this could sometimes be completed during the working day. But team members could also access the online training modules at home if needed. The dispenser said that she was due to carry out the staff performance reviews and appraisals.

The dispenser said that information was passed on to team members informally and there were no formal meetings held in the pharmacy. There were regular conference calls between the pharmacy, the area manager and the pharmacy's head office. The dispenser said that she felt that she could discuss any issues with the pharmacist during the working day. And she was in regular contact with the pharmacy's head office. The pharmacy regularly received updates from head office highlighting any issues throughout the organisation and this information was available on the pharmacy's intranet.

Targets were set for Medicines Use Reviews (MUR) and the New Medicine Service (NMS). The dispenser said that the pharmacy was on course to meet the MUR target, but it was struggling with the NMS target due to the surgery not being fully open yet. The pharmacy kept a list of declined NMS opportunities to show the reason for the target not always being met. The pharmacist said that she did not feel under pressure to achieve the targets and would not let these affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises largely provide a safe, secure and clean environment for the pharmacy's services.

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 and 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 during the inspection was above 30 degrees Celsius. The unit was towards the rear of the dispensary and several fans were also in use around the pharmacy. The air-conditioning unit was in constant use during the inspection, but it did not appear to be blowing out cool air. The room temperature had been monitored daily and the temperature had reached 35.8 degrees Celsius at times. The main entrance to the pharmacy was left open during the day. The dispenser said that she had reported the temperatures to the pharmacy's head office, but the issue had not yet been resolved. Team members said that their concentration was affected due to the high temperatures in the pharmacy. And it was uncomfortable to work in the pharmacy. The inspector contacted the pharmacy's head office on the day of the inspection and was provided with details about how the issues would be addressed. An engineer would service the air-conditioning machine and it would be replaced if needed. And the facilities manager would seek to install a more permanent air-conditioning machine if possible.

Floor space in the pharmacy was limited but the team kept it as clear as possible to help minimise the tripping hazards. A small screen had been installed at the medicines counter. It was not wide enough to cover the whole counter and people generally stood to the side of it when speaking with team members. Notices to encourage people to wear face coverings while inside the pharmacy were displayed at the entrance to the pharmacy. The entrance to the pharmacy was the same entrance used by people accessing the surgery. A line was used on the floor outside to divide people into two different queues. Only one person was allowed in the pharmacy shop area at a time. Markings were used on the floor with a written notice asking people to keep one metre apart. And a delivery box had been placed on the floor to help people maintain distance from the pharmacy counter. This helped team members to maintain a suitable distance from people using the pharmacy.

There were two 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. And they had been placed over two metres apart to ensure that social distancing could be maintained by people using them. 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 it was not accessible to wheelchair users due to some shelves outside the room. Toilet facilities were available in the surgery and there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

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

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.

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 dispenser said that the monitoring record books for people taking high-risk medicines such as methotrexate and warfarin were not currently being checked. This was to help minimise the risk of infection spread during the pandemic. Prescriptions for Schedule 3 and 4 CDs were highlighted. The dispenser knew that prescriptions for these medicines were valid for 28 days. She said that the pharmacy supplied valproate medicines to a few people. But there were no people in the at-risk group who needed to be on a Pregnancy Prevention Programme. The pharmacy had the up-to-date patient information leaflets and 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 six months was marked with a 'use this pack first' sticker. There were no out-of-date medicines found with dispensing stock and items were kept in their original packaging. Fridge temperatures were checked daily, and the 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 had been recorded as 9.1 degrees Celsius when it was checked in the morning. The maximum temperature had been recorded as being above the recommended range for the past several days and it had been recorded as 12.2 degrees on 6 August 2020. The dispenser said that she had reported this to the pharmacy's head office and she thought that the reason for the high temperatures was possibly due to the excessive temperature in the pharmacy. The weather had been very hot and sunny around the time of the inspection. The pharmacy's head office provided assurance that a fridge engineer would service the fridge and the temperatures would be checked every hour.

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. The dispenser said that uncollected prescriptions were checked regularly and items uncollected after around three weeks were removed from the collection area and people were sent a text message reminder. A second reminder was sent a week later and if the items remained uncollected, these were then returned to dispensing stock when possible. The prescriptions were returned to the prescriber or the NHS spine. People's medication records were updated to reflect that they had not collected the items.

Assessments had been carried out for people who received their medicines in multi-compartment compliance packs. 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 dispensed and checked each pack. Medication descriptions were put on the packs and the patient information leaflets were routinely supplied. The dispenser wore gloves while assembling the packs so that she was not touching the medicines.

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 kept separate. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by delivery drivers. The pharmacy had been using a volunteer to help with the increased requests for deliveries due to the coronavirus. But the volunteer was due to go back to work and they would not be available in the near future. The pharmacy previously obtained people's signatures for deliveries where possible and these had been recorded in a way so that another person's information could be protected. But due to the coronavirus, the pharmacy was not asking people to sign for their medication to help minimise the spread of infection. 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 person to contact the pharmacy to rearrange delivery.

Licensed wholesalers were used to obtain medicines and medical devices. Drug alerts and recalls were received from head office. Any action taken was recorded to show what the pharmacy had done in response. The pharmacy had the equipment ready for the implementation of the Falsified Medicines Directive, but team members had not been shown how to use it. And it was not being used.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

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 dispenser said that she would order a suitable measure. 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. Alcohol gel, face masks and gloves were available.

Team members wore face coverings, regularly washed their hands and used hand gel to help minimise the risk of contracting or spreading the coronavirus. Disposable gloves were available.

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.