General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crook Log Pharmacy, 329 Broadway, BEXLEYHEATH, Kent, DA6 8DT

Pharmacy reference: 1090265

Type of pharmacy: Community

Date of inspection: 04/02/2020

Pharmacy context

The pharmacy is located on a busy high street near to a town centre in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations (seasonal) and blood pressure checks. It also provides medicines as part of the Community Pharmacist Consultation Service. And 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.

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 largely protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It largely 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 adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs). 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. The dispenser said that near misses were recorded and reviewed regularly for any patterns, but she could not find the near miss log during the inspection. 'High alert' stickers were used to highlight areas in the dispensary where errors had happened. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser could not locate the folder where any dispensing incident reports might be kept. She said that she was not aware of any recent incidents.

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 said that the pharmacy would open if the pharmacist had not turned up, but she knew that she should not carry out any dispensing tasks, sell any medicines or hand out any dispensed items. She explained that she would contact one of the pharmacy owners to let them know if the pharmacist had not arrived.

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. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. And there signed in-date patient group directions available for the relevant services offered. 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. The dispenser was not sure where the paperwork for the unlicensed medicines was kept but said that the pharmacy had not made any recent supplies of these medicines. The private prescription records were largely completed correctly, but the prescriber's details and the date on the prescription were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. 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.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. 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 not be viewed by people using the pharmacy. The pharmacy obtained people's signatures for deliveries where possible. There were multiple people's details on each sheet so the layout might make it harder to ensure that other people's details were protected when signatures were recorded. The dispenser said that she would ensure that other people's personal information was protected when signatures were recorded in the future.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and 100% of respondents were satisfied with the pharmacy and its staff overall. The dispenser said that she was not aware of any complaints from people about the pharmacy. The complaints procedure was available for team members to follow if needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser said that she had not completed any safeguarding training, but she could describe potential signs that might indicate a safeguarding concern. And she said that she would refer any concerns to the pharmacist. The dispenser 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 an adequate number of 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 or make suggestions and have regular meetings. 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. And they discuss adverse incidents and use these to learn and improve.

Inspector's evidence

There was one locum pharmacist, two trained dispensers and one trainee dispenser working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and team members were managing the workload adequately. The dispenser said that there had been a team member leave recently and one of the medicines counter assistants had been placed on an accredited dispenser course so that they could provide cover. The dispenser said that she had been doing additional hours to help out. A dispenser from another pharmacy within the organisation was working at the pharmacy on the day of the inspection to help catch up on dispensing and other tasks.

The team appeared confident when speaking with people. One of the trained dispensers, when asked, was aware of the restrictions on sales of pseudoephedrine containing products. She said 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 explained that they completed online modules provided by an external agency. They said that these were checked by the pharmacist and they completed them at home. The pharmacist was aware of the continuing professional development (CPD) requirement for the professional revalidation process. He said that he was also a qualified nurse and he had recent undertaken some CPD for this role. He said that he was due to undertake some training for his role as a pharmacist. And he said that he felt able to take professional decisions. The dispenser said that team members discussed any mistakes openly in the team.

The dispenser said that the owners of the company (who worked at the pharmacy) carried out ongoing informal appraisals and performance reviews. She said that she was due to have a more formal one next month. She explained that there were daily informal meetings held to discuss tasks and which ones were to take priority. She said that she had a good working relationship with the pharmacy company's owners and she felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The pharmacist said that he provided the services for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises largely 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 was a small padded bench in the shop area. It was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area.

Toilet facilities were clean and there were separate hand washing facilities available. There were two large cupboards in the toilet area and these were used to store large amounts of medicines people had returned for destruction. Some of the medicines required denaturing prior to disposal and the inspector discussed this with the trainee dispenser at the time. She said that she would sort the medicines and ensure that any which required denaturing were segregated and disposed of appropriately. Storing medicines in the toilet area made it harder for the pharmacy to show that these medicines were being kept securely.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. It dispenses medicines into multi-compartment compliance packs safely. And people with a range of needs can access the pharmacy’s services. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. But it could do more to ensure that its date-checking routine is sufficiently effective. 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 a small step into 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. The dispenser explained that dispensing people’s prescriptions was taking priority at the moment over some of the other tasks in the pharmacy so that people received their medicines when needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The dispenser explained that prescribers in the area would usually only prescribe a small amount of medicine for someone if they needed to have a blood test. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. 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 dispenser 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. The pharmacy had the relevant patient information leaflets and warning cards available.

Stock was largely stored in an organised manner in the dispensary. A full expiry date check had not been carried out for several months and short-dated items were not marked. The dispenser said that they would use coloured stickers to highlight these in the future and keep lists of these items so that they could be removed promptly. There were several date-expired items found in with dispensing stock. And several medicines were found which were not kept in their original packaging. The packs they were in did not include all the required information on the container such as batch numbers or expiry dates. There were several packs which contained mixed batches found with dispensing stock. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The dispenser said that other tasks had taken priority while the pharmacy had been short staffed. But she said that she would implement a more reliable system to ensure that items were removed from dispensing stock before they had passed their 'use-by-date'.

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 dispenser said that uncollected prescriptions were checked every six months. There were several expired prescriptions for items waiting collection. Including one for a Schedule 3 CD which was written in August 2019. This could increase the chance of these items being handed out when the prescription was no longer valid. The dispenser said that she would ensure that any expired prescriptions would be removed and the items returned to dispensing stock where possible.

The trainee dispenser said that people's GPs carried out assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. The trainee dispenser said that prescriptions for 'when required' medicines were not routinely requested. She confirmed that the pharmacy routinely contacted people to ask if they needed them when their packs were due. 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 suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the warnings and cautionary advisory labels were not recorded on the backing sheets. The dispenser said that she would contact the computer medication record provider to request that these be added. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were supplied most of the time. The trainee dispenser said that some people had expressed that they did not want to have the leaflets. But this could make it harder for people to have up-to-date information about how to take their medicines safely. Team members wore gloves when handling medicines that were placed in these packs.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. Expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded. There were no returned CDs found in the CD cabinet.

Deliveries were made by a delivery driver. 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 kept a list of people's items out for delivery so that people could be informed if they contacted the pharmacy.

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 team were not sure when the pharmacy was likely to start using the equipment.

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 but not all of them were suitable for pharmacy use. The trainee dispenser said that she would inform the regular pharmacist. Triangle tablet counters were available and 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 dispenser said that she was not sure how long the blood pressure monitor had been in use for. 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.

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.