General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Iwade Pharmacy, Units D & E Iwade Village Centre, The Street, Iwade, SITTINGBOURNE, Kent, ME9 8SH

Pharmacy reference: 1091885

Type of pharmacy: Community

Date of inspection: 14/04/2021

Pharmacy context

The pharmacy is in small shopping precinct in a village centre. The people who use the pharmacy are mainly older people. The pharmacy provides a range of services, including the New Medicine Service and a stop smoking service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to several people who live in their own homes to help them manage their medicines. 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 to help provide them safely. It protects people's personal information well. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. The pharmacy mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. When a dispensing mistake happens, team members respond well. But they don't always record mistakes that happen during the dispensing process. And this could mean that they are missing out on opportunities to learn and improve the pharmacy's services.

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), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood and agreed to follow the SOPs. 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 usually identified and rectified their own mistakes, but the pharmacist would point out the mistake during busier periods. Near misses were recorded on the pharmacy's computer system and reviewed regularly for any patterns. The pharmacist accepted that all of the recent near misses might not have been recorded. He printed a near miss log and said that this would make it easier for team members to record them during the dispensing process. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form on the pharmacy's computer system and a root cause analysis was undertaken. There had not been any recent dispensing incidents reported to the pharmacy. The pharmacy had carried out workplace risk assessments in relation to Covid-19 and a SOP was available for team members to follow.

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. There were baskets taking up much of the workspace in the dispensary. But team members had clear areas to dispense and check medicines. 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 she would attempt to contact the pharmacist if he had not turned up in the morning. And she would signpost people to other pharmacies in the local area if needed. She knew that dispensing tasks should not be carried out if there was no responsible pharmacist (RP) signed in. And that pharmacy-only medicines should not be sold and dispensed items should not be handed out if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was

clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier 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. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that he would ensure that these were recorded correctly in future.

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 previously carried out yearly patient satisfaction surveys. But this had not happened last year due to the pandemic. People were occasionally sent a text message by the pharmacy to invite them to provide feedback about the services. The complaints procedure was available for team members to follow if needed. The pharmacist said that he was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education Level 2 training about protecting vulnerable people. Other team members had been provided with some safeguarding training and one of the dispensers had undertaken some safeguarding training at a pharmacy she had worked at previously. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The team members could give examples of action they had taken in response to safeguarding concerns. 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 some ongoing 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. 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.

Inspector's evidence

There was one pharmacist and two trained dispensers working at the pharmacy during the inspection. Team members had completed an accredited course for their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. And 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 was aware of the continuing professional development requirement for the professional revalidation process. There was currently no formalised ongoing training for team members, but the pharmacist explained how he passed on information to the team during the day. He said that the team would undergo more structured training when the workload allowed time for this. The workload had increased during the pandemic. The pharmacist mentioned that the Local Pharmaceutical Committee had made some training available to the pharmacy and this would be used in the future.

The inspector discussed with the pharmacy about the reporting process in the event that a team member tested positive for the coronavirus. The pharmacist felt able to take professional decisions. Targets were not set for team members and services were provided for the benefit of the people using the pharmacy.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. A communication book was used to pass on messages to the delivery driver. The team thought that this worked well and had discussed having one in the dispensary. The pharmacist said that the team were due to undergo skills appraisals with him and these would be documented.

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 and the room temperature was suitable for storing medicines.

The pharmacy was limiting the number of people in the shop area to two at a time. This helped people to maintain a suitable distance from each other. There were also signs on the floor to help. There were two chairs in the shop area and these were set at a suitable distance from each other. And they were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy's main 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 not used for storing pharmacy items. There were separate handwashing 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, so that people get medicines and medical devices that are safe to use. And it dispenses medicines into multi-compartment compliance packs safely. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity 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.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were not routinely highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The team knew how long these prescriptions were valid for and the pharmacist had ordered stickers which would be used to highlight the prescription for these medicines. The team checked CDs and fridge items with people when handing them out. Patients taking valproate medicines were provided with warning cards and patient information leaflets. 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.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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 pharmacist said that uncollected prescriptions were checked regularly. If people had not collected their items after two months the medicines were returned to dispensing stock where possible. The patient medication record was updated to reflect this, and the prescriptions were returned to the NHS electronic system or to the prescriber.

Assessments had been carried out for people who had requested that their medicines be dispensed 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. Prescriptions for 'when required' medicines were not routinely requested; the pharmacist said that people usually contacted the pharmacy when they needed these medicines. 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 suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines 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 did not currently obtain people's signatures to help minimise the spread of infection. 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 delivery driver wore personal protective equipment and maintained a suitable distance from people they were delivering to. This helped minimise the spread of infection.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. And 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.

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. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Team members wore masks while at work and hand sanitiser was available.

Up-to-date reference sources were available in the pharmacy and online. The weighing scales in the shop area appeared to be in good working order. And the shredder worked. 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.