General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Anglesea Healthy Living Centre, 1 Kent Road, St. Mary Cray, ORPINGTON, Kent, BR5 4AD

Pharmacy reference: 1097324

Type of pharmacy: Community

Date of inspection: 15/03/2022

Pharmacy context

This is a pharmacy in a largely residential area near a GP surgery. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It provides a delivery service to people's homes. And it dispenses medication into multi-compartment compliance packs for some people who need help taking their medicines. The inspection was undertaken during the Covid-19 pandemic.

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 not all met	1.7	Standard not met	The pharmacy does not always obtain the appropriate consent from people when it provides its services. And it does not always dispose of its confidential waste properly.
2. Staff	Standards not all met	2.2	Standard not met	The pharmacy does not always enroll its staff on the appropriate training courses within the required time periods.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.4	Standard not met	The pharmacy does not have a robust system to appropriately deal with safety alerts such as drug recalls.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not always obtain the appropriate consent from people when it provides its services. And it does not always dispose of its confidential waste properly. However, it otherwise manages the risks associated with its services adequately. It generally keeps the records it needs to, to show that medicines are supplied safely and legally. Staff have some knowledge of how to protect the welfare of vulnerable people. When a dispensing mistake happens, staff generally respond well. But they don't always record these mistakes, which could mean that staff are missing out on opportunities to make the pharmacy's services safer.

Inspector's evidence

There was a folder containing standard operating procedures (SOPs), but the procedures were around five years old and no longer being used. Most staff present had not read through them, including the responsible pharmacist (RP). The superintendent pharmacist (SI) explained that new SOPs had already been ordered in and were at the pharmacy's head office. And following the inspection, the pharmacy confirmed that these SOPs had now been brought to the pharmacy and staff would be signing to show that they had read and understood them. Team members were able to explain what they would do if the pharmacist had not turned up in the morning. And knew what they could and could not do if the RP was not present.

A book was available in the dispensary to record dispensing mistakes which were identified before the medicine was handed to a person (near misses). The book had not been regularly used, and most entries were from 2019. The RP had already started using the book again earlier on the day of inspection and said it would be used going forward. He gave an example of a near miss where the wrong strength had been dispensed. He had talked with the dispenser about the mistake and said that the different strengths would be separated on the shelves. The RP explained how he would record dispensing mistakes where the medicines were handed to a person (dispensing errors) on the National Reporting and Learning System. But he was not sure about the system the pharmacy used. The SI said that the pharmacy was in the process of having a new computer system installed and he would review how staff could use it to record dispensing errors.

The right RP notice was displayed, and samples of the RP record seen had largely been filled in correctly. Records of private prescriptions dispensed were recorded on the computer system, and the entries examined complied with requirements. Some records of supplies of medicines in an emergency without a prescription (emergency supplies) did not contain a reason as to the nature of the emergency. And this could make it harder for the pharmacy to show why an emergency supply had been made if there was a query. Records of unlicensed medicines supplied did not contain all the required information, and the RP said that this would be rectified. Controlled drug (CD) registers seen largely complied with requirements, but there was some crossing out. The RP was undertaking a CD balance check at the time of the inspection. There were some records of date-expired CDs being destroyed by the previous pharmacist, but these were not signed by anyone. Following the inspection, the previous pharmacist provided evidence that he had been authorised to destroy them by the local CD Accountable Officer. And he said that he would countersign entries of this type in the future.

People could provide feedback or make complaints at the pharmacy or by writing in. The pharmacy had

received recent complaints about the waiting time, and about being unable to obtain medicines for prescriptions. The RP said that there had been problems in obtaining some medicines from suppliers. And if there were issues, he tried to obtain them from other branches or ask the person's GP to prescribe an alternative. He explained that he referred complaints to the SI if they were unable to be resolved in the pharmacy. The pharmacy did not have a written complaints procedure, but the SI understood this would be included in the new set of SOPs.

The pharmacy had a current indemnity insurance certificate displayed. Confidential information was generally stored appropriately, but on some bag of medicines awaiting collections, people's address labels could potentially be seen by people waiting. The day after the inspection the pharmacy provided evidence to show that this had been resolved by putting the bags into boxes so that the details were not visible. A shredder was available for disposing of confidential waste, but a small amount of confidential material was found in with general waste. This was removed, and the team members informed. The dispenser understood that the new SOPs contained a procedure around information governance, and the staff would be reading through it.

The pharmacy had stopped dispensing multi-compartment compliance packs for most people and moved the majority of this dispensing activity to another branch. This had been started around two or three weeks ago to help the pharmacy whilst it was having staffing issues. However, the SI confirmed that consent had not been sought from these people to do this. He said that he would review this and obtain consent from people who were affected by the change.

The RP confirmed he had completed the level 2 safeguarding course and with some prompting, could describe what he would do if he had any concerns about a vulnerable person. Staff said that they would refer any safeguarding concerns to the pharmacist.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not always enrol its staff on the appropriate training courses within the required time periods. The pharmacy has struggled with staffing levels, but now has just enough team members to provide its services safely. They feel able to raise any concerns or make suggestions. And they can take professional decisions to help ensure that people are kept safe. Team members have access to some ongoing training, but this is not very structured. And this could make it harder for them to keep their knowledge and skills up to date.

Inspector's evidence

The regular pharmacist had recently stopped working at the pharmacy, and some other team members had also left around the same time. The pharmacy had fallen behind on its workload after this had happened. During the inspection the pharmacy was busy, but the SI said that the team was catching up and the workload was now more or less up to date. New staff had been recruited and were working in the pharmacy, with more due to be recruited in the coming weeks. The majority of dispensing seen was for prescriptions dated the day of the inspection or the day before.

At the time of the inspection there was the RP (long-term locum), the SI, two trained dispensers (both usually based in the pharmacy's head office), a delivery driver, and three other members of staff. Of the three other members of staff, one had worked in the pharmacy for around two months and was due to start a dispenser course. Another had started work on the pharmacy counter a few weeks ago and was not yet registered on a course. And the third was working as a dispenser since December 2021 and had not yet been registered on a dispenser course. The delivery driver had worked at the pharmacy for over three months and had not yet started any accredited training.

Staff felt comfortable about making suggestions and raising concerns. They had provided feedback about the pharmacy's computer system and said that it was very slow and crashed often. And this caused delays in helping people using the pharmacy. As a result, the pharmacy was installing a new faster computer system on the day of the inspection. Staff had also raised concerns that the phone was constantly ringing, and it was sometimes hard to answer it in time. And the pharmacy was due to install a new phone system which would allow for a queuing system. Staff had received some abuse from people using the pharmacy, and there were signs displayed explaining that abuse would not be tolerated.

The RP felt fully able to take professional decisions. Staff were not given any targets. They had access to information about new products from manufacturers and pharmacy magazines, but there was no structured ongoing training. The SI said that previous staff had attended evening training seminars, but the current team was relatively new and they had not had this opportunity yet.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy's premises are suitable for providing its services. People can have a conversation with a team member in a private area. The premises are kept secure from unauthorised access.

Inspector's evidence

The premises were generally clean and tidy, and there was enough clear workspace to allow for safe dispensing. Lighting was good throughout. The floor was marked in places, and the dispenser said that a new floor was going to be fitted. Fixtures and fittings were suitable for their intended purpose. The premises were secure from unauthorised access.

On the day of the inspection the pharmacy was having a new computer system installed, and boxes for this were cluttering the consultation room, but this was only until the new system was installed. The room was otherwise clean and allowed for a conversation at a normal level of volume to take place inside and not be overheard from the shop area. The dispenser said that the pharmacy was considering putting a physical barrier up between the pharmacist and people using the pharmacy, to help cut down on the potential for the pharmacist to be distracted.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not have a robust system to appropriately deal with safety alerts such as drug recalls. So, there is an increased risk that people may receive medicines or medical devices that are not safe to use. However, overall the pharmacy otherwise provides its services in a generally safe way. And people can access its services. The pharmacy gets its medicines from reputable suppliers and largely stores them properly.

Inspector's evidence

There was a small step from the street, and there was an adjacent handle to help people get into the pharmacy. A doorbell could be used for someone to attract the attention of staff. The dispenser believed the pharmacy had a portable ramp, but she would check and make sure one was obtained if she could not find it. Some team members were multilingual, and the pharmacy had the facility to generate large print labels. The pharmacy had previously had complaints from people being unable to get through to the pharmacy on the phone. During the inspection the phone was ringing frequently, and staff were seen to answer it reasonably promptly. The pharmacy was due to install a new phone system which would enable people to wait in a queue for the phone to be answered. Or to select options such as reordering a repeat prescription.

The pharmacy was planning to open a Covid vaccination centre elsewhere in the building. This would not be running from the registered premises and would have a supervising pharmacist on-site. The SI was referred to the guidance available about this on the GPhC website.

Baskets were used during the dispensing process to separate different people’s medicines. The pharmacy was busy, but there was a clear workflow through the dispensary. The pharmacy had stopped dispensing multi-compartment compliance packs for most people and moved the majority of this dispensing activity to another branch. The packs were dispensed by the other branch and supplied by this pharmacy. The SI did not believe that it was made clear on the packaging that the packs had been dispensed by one pharmacy and supplied by another. He said that he would look into this. A small number of people still had their packs dispensed at this pharmacy, usually people who needed their medicines urgently. The prepared packs seen were labelled with a description of the medication inside, and patient information leaflets were routinely supplied. Staff were unsure how people were assessed to see if they needed to start using the packs.

The SI described how he had recently talked to the team members to ask them to supply ‘owing’ notes to people if the pharmacy was unable to supply all their medicines. Dispensed prescriptions for CDs were not always highlighted, which could make it harder for the team member handing them out to check if the prescription was still valid. Staff found a sticker which could be used for this purpose in the future. Dispensed prescriptions for higher-risk medicines such as warfarin and methotrexate were also not routinely highlighted, but there were none found on the shelves. Staff located another sticker to help the member of staff handing the medicine out to know if they should check with the pharmacist first. The pharmacist was aware of the additional guidance about pregnancy prevention for people receiving valproate medicines. He was not aware of any people in the at-risk group who used the pharmacy. Warning cards were attached to the individual boxes of valproate-containing medicines.

Medicines were obtained from licensed wholesaler dealers and specials suppliers, and they were generally stored in a tidy manner on the shelves. The RP said that there had been difficulties in obtaining some stock from suppliers. The pharmacy had recently had an external team in to date-check the stock medicines, and no date-expired medicines were found in with stock on the shelves sampled during the inspection. Routine date checks by staff were not regularly recorded, and the dispenser said that this would be done in the future. Following the inspection, the pharmacy confirmed that a new system to enable regular date checks of stock had started.

Bulk liquids were not always marked with the date of opening, which could make it harder for staff to know if they were still suitable to use. Two containers of medicines were found in with stock. The containers were not labelled with a batch number or expiry date and were removed for destruction. Medicines requiring cold storage were stored in a large fridge. The temperature records seen showed the fridge had been kept within the required range. The current temperature of the fridge during the inspection was within range, but the minimum and maximum temperatures were out of range. Staff said that they would make sure the temperature probe was appropriately located in the fridge and would ensure the thermometer was reset each day.

The last drug alerts and recalls found were from 2019. Staff said that the pharmacy received further alerts or recalls via email from the MHRA. But they did not know who checked the emails and there was no clear responsibility as to who should ensure the appropriate action was undertaken in response. No evidence was found that recent safety alerts had been appropriately actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it takes steps to improve its equipment in response to feedback. It uses its equipment to help protect people's private information.

Inspector's evidence

There were clean glass measures, with some marked for use only with certain liquids. Tablet counting triangles were clean. The pharmacy was in the process of having a new computer system installed, which the SI said would be faster and enable staff to work more efficiently. The phone was cordless and could be moved to a more private area to help protect people's personal information. A new phone system was due to be installed, which would allow for a call waiting system and enable people to select options such as reordering repeat prescriptions.

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.