General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Mistvale Chemist, 138-140 High Street, WELLING, Kent, DA16 1TJ

Pharmacy reference: 1106442

Type of pharmacy: Community

Date of inspection: 17/09/2020

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. The pharmacy provides a range of services, but most had been suspended temporarily due to Covid-19. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to some 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 records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. And team members understand their role in protecting vulnerable people. The pharmacy largely protects people's personal information properly and people can provide feedback about the pharmacy. And it mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included the reporting and reviewing of dispensing mistakes. 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. Near misses were recorded and reviewed regularly for any patterns, and items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. 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 type of medicine had been supplied to a person. The pharmacist said that she had informed the superintendent pharmacist and the right medicine was given to the person.

The pharmacist said that the superintendent (SI) pharmacist had taken the standard operating procedures (SOPs) to review and update them. Following the inspection, she confirmed that the SOPs had been returned to the pharmacy. Not having the SOPs available for the team members to refer to may make it harder for them to know what the right procedures are.

The pharmacy had carried out workplace risk assessments in relation to Covid-19. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus. The pharmacist said that she would look at the regulations and ensure that it was reported to the correct authority.

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.

The trainee dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And other team members would not be able to access the pharmacy. She confirmed that she would not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. And all

necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were completed correctly. 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. Not all the required information was recorded when prescription-only medicines were supplied in an emergency. The pharmacist said that these supplies were made as a loan against an expected prescription. She confirmed that she would ensure that the necessary records were kept in the future and that the nature of the emergency would be recorded.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used her own smartcard to access the NHS electronic services. And bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacist said that she had not completed training about the General Data Protection Regulation, but she would look into this. Away from the shop floor, there was some people's personal information which was not properly secured. The pharmacist gave assurances that this would be moved to somewhere more secure as soon as possible.

The pharmacy carried out patient satisfaction surveys and the most recent results available on the NHS website were from the 2017 to 2018 survey. The pharmacist said that the superintendent pharmacist usually dealt with collating the information from the surveys. Team members were aware of the pharmacy's complaints procedure and details about it were available in the pharmacy's practice leaflet. The pharmacist was not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The trainee dispenser said that she had not undergone any safeguarding training. But 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 not been 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 team members to provide its services safely. Team members 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.

Inspector's evidence

There was one pharmacist and one trainee dispenser working at the start of the inspection. The trainee dispenser was enrolled on an accredited course for her role. She had previously been enrolled onto a medicine counter assistant course, but had not completed this within the required timeframe. She was now undertaking a combined medicines counter and dispensing course. Part-way though the inspection, the trainee dispenser finished her shift and a trainee medicines counter (MCA) assistant started her shift. The trainee MCA said that she had worked at the pharmacy for around two years and had previously been enrolled on an accredited course, but she had not completed it and was not currently enrolled on a suitable course. Following the inspection, the pharmacist confirmed that the trainee MCA had been enrolled on an accredited course for her role.

The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. Having a well-managed workload meant that the trainee dispenser spent time on her course work during the working day. The team also had regular reviews of any dispensing mistakes and discussed these openly in the team.

The trainee dispenser appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. And 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.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. The pharmacist said that she felt able to take professional decisions.

The pharmacist said that she carried out ongoing informal appraisals and performance reviews with the trainee dispenser. The trainee dispenser said that she felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said that she was in regular contact with the SI and could discuss any issues with him. She said that he worked at the pharmacy on Saturdays.

Targets were not set for team members. The pharmacist confirmed that she carried out the services for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And people can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access and pharmacy-only medicines were kept behind the counter. It was bright, clean and tidy throughout, and this presented a professional image. 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. A clear screen had been installed at the medicines counter to help minimise the spread of infection.

There was one chair in the shop area and it was positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacy's 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 hand washing facilities available. The tap at the sink in the dispensary was broken and the water was constantly running. The pharmacist said that this had been reported to the SI on several occasions but had not yet been fixed. She said that she would chase it up.

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 largely stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But 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 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 she was not currently checking people's monitoring record books for higher-risk medicines such as methotrexate and warfarin to help minimise the spread of infection. 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 CDs were highlighted, and the date when the prescription was valid until was written on the top of the prescription. Prescriptions for Schedule 4 CDs were not highlighted and the trainee MCA was unsure how long these prescriptions were valid for. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that she would ensure that prescriptions for higher-risk medicines and Schedule 4 CDs were highlighted in the future. She confirmed that Schedule 2 CDs and fridge items were checked with people when handing them out. The pharmacist 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 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 were marked. There were no date-expired items found in with dispensing stock. Medicines that people had returned were kept separate from stock, but not all of them were stored securely. The pharmacist gave assurances that these would be moved to a more secure area as soon as possible.

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 and people were sent a text message reminder if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that she carried out assessments for the people who had their medicines in multi-compartment compliance packs to show that they needed the packs. And she regularly reviewed their

needs. Prescriptions for people receiving their medicines in the 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 contacted the pharmacy to see if they needed them when their packs were due each month. 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 checked each pack. But there was no audit trail to show who had dispensed them. This could make it harder for the pharmacy to identify who had dispensed them and limit the opportunities to learn from any mistakes. 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 ask for people to sign for their medicines, 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 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 and this made it easier for the pharmacy to show what it had done in response. The pharmacist was not sure if the pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive. She said that she would check with the SI.

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. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor had been in use for less than one year. The weighing scales and 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. Team members wore masks throughout the inspection to help minimise the spread of infection. The pharmacy had masks, gloves, aprons and alcohol gel available.

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. There had been one occasion recently where the pharmacist had checked the fridge on a Monday morning and it was not switched on. She moved the fridge slightly and it powered up. She was not sure how long the fridge had been off for, so she had quarantined the stock and informed the SI.

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.