General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Central Pharmacy, 142 Northdown Road, Cliftonville, MARGATE, Kent, CT9 2QN

Pharmacy reference: 1106929

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

The pharmacy is open 100 hours a week and is surrounded by residential premises. It is located in a seaside town. The people who use the pharmacy are mainly older people. Many of the residents were from other countries. The pharmacy receives around 70% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews and the New Medicine Service. It provides multi-compartment compliance aids to around 30 people who live in their own homes to help them take their medicines safely. And provides substance misuse medications to around seven people.

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

The pharmacy generally identifies and manages the risks associated with its services. It generally protects people's personal information. And it seeks feedback from people who use the pharmacy. It largely keeps its records up to date. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs). Team members had signed to indicate that they had read and understood the SOPs. The superintendent (SI) pharmacist said that near misses were highlighted with the team member involved at the time of the incident. And they identified and rectified their own mistakes. There had only been one near miss recorded in the log since 2015. He said that he would ensure that the log was used and regularly reviewed for trends and patterns. This may help team members learn from any mistakes to help make the services safer. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where a bag of medicines had been delivered to the wrong person. The delivery driver said that the people lived near to each other on the same road. She said that the driver at the time had not confirmed the person's name before handing over the medicines. She said that this is something that she always checked.

Workspace in the dispensary was generally free from clutter. But the checking area was a little cluttered with paperwork and other items. 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 delivery driver said that she would contact the SI or regular locum pharmacist if the pharmacist had not turned up. She knew that team members were not allowed to sell any medicines, carry out dispensing tasks or hand out bagged items if the pharmacist had not turned up. The trainee medicines counter assistant (MCA) knew that she should not sell 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 in place. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. The pharmacy had recently supplied medicines against a couple of private prescriptions which did not have the date or prescriber's address on. The SI said that he would ensure that all prescriptions were legally valid at the time of supply. The electronic private prescription record and emergency supply record were not available to view due to the computer crashing during the inspection. The SI said that he always recorded the nature of emergency when he made a supply of a prescription only medicine in the absence of a prescription.

Most controlled drug (CD) running balances were checked around once a month. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The full date that a CD was supplied was not routinely recorded in the CD register. Many entries only had the day recorded. There were alterations made to the CD records. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query. Several headings were not completed. The SI said that he would ensure that the registers were competed correctly. The correct responsible pharmacist (RP) notice was clearly displayed and the RP log was completed correctly.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. But Smartcards used to access the NHS spine were being shared. One was in use which belonged to a pharmacist who was not working on the day of the inspection. This could mean that it may not always be clear who has accessed the system if there was a query. The SI said that he would apply for Smartcards for other members of the team. Dispensed items awaiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys. There were no results available to view during the inspection. The complaints procedure was available for team members to refer to where needed. The SI said that the pharmacy had not received any complaints recently.

The SI said that he had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members said that they had not completed safeguarding training. But delivery driver could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. 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. Although it could do more to make sure that they are registered on accredited training courses in a timely manner. Team members can raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy.

Inspector's evidence

There was one pharmacist (who was the SI) and one dispenser working at the start of the inspection. A trainee MCA and trainee dispenser were also working during the latter part of the inspection. The dispenser said that she had completed an NVQ level 3 pharmacy course. The delivery driver had previously been enrolled on an accredited counter assistant course. But she had not completed it within the required timeframe. She carried out tasks in the dispensary including keeping the bags, bottles and other sundry items fully stocked, and answering the telephone. But she did not undertake any dispensing tasks. She said that she was due to be enrolled on another accredited course soon. The team members worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The trainee MCA was carrying out some dispensing tasks during the inspection. She had worked at the pharmacy for around one year. But had only recently been enrolled on an accredited counter assistant course. The SI enrolled the trainee MCA and the delivery driver on a accredited dispenser courses during the inspection.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She confirmed that 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 said that they did not undertake regular training modules aside from the accredited courses. The delivery driver said that some team members had completed recent training on inhaler technique, blood pressure and diabetes.

The delivery driver said that there were pharmacy meetings held but these were infrequent. She said that most communication was informal. Some team members said that the SI was understanding when they had issues outside the pharmacy and they were able to change their shifts around with other team members when needed. They said that they felt confident to discuss any issues with the SI and he tried to help them where he could. Targets were not set. The SI said that he carried out services for the benefit of the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally 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. But there were some that were not properly secured. The SI said that this would be addressed. He had a clear view of the medicines counter from the dispensary. He could listen to conversations at the counter and intervene where needed.

Air-conditioning was available; the room temperature was suitable for storing medicines. 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.

The consultation room was accessible from the shop area and dispensary. The door to the shop area was kept locked when not in use. Low-level conversations in the consultation room could not be heard from the shop area. There were two chairs and a desk available. The room was accessible to wheelchair users. A sink was available. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well. It gets its medicines from reputable suppliers. And largely stores them safely and manages them well. But it does not always keep medicines in appropriately labelled containers. This may mean that it is harder for it to take appropriate action when there is a medicine recall or alert.

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. A variety of patient information leaflets were available. Services and opening times were clearly advertised. The trainee dispenser could speak a few different languages. Several people who used the pharmacy could not speak English. And she was able to translate for them so that they received the service they needed.

The SI said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. He said that a record of results was not kept on the person's medication record. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for these medicines were not highlighted so there is potential that the opportunity to speak with these people is missed. The SI said they checked CDs and fridge items with people when handing them out. Prescriptions for schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription has expired.

The SI said that there were currently no people taking valproate medicines who needed to be on the Pregnancy Prevention Programme. The pharmacy did not have the patient information leaflets or warning cards available. The SI said that he would order replacements from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Short-dated stock items were generally marked. Medicines were not always kept in appropriately labelled containers. There were several foil strips of medicines found with dispensing stock. Many did not have a batch number or expiry date on. This could increase the chance of people receiving medicines which were past their 'use-by' date. And may mean that it cannot take appropriate action when there is a medicine recall or alert. The SI said that he would ensure that medicines were kept in their original packaging.

The SI said that part-dispensed prescriptions were checked regularly. 'Owings' notes were provided and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. The SI said that items uncollected after around three months were returned to dispensing stock where possible. He confirmed that electronic prescriptions were returned to the NHS spine and others were disposed of appropriately in the pharmacy. And the patient's medication record was updated. Prescriptions were not always kept with the medicines until they were collected. This could increase the chance of these being handed out when the prescription had expired. The SI said that he would ensure that prescriptions were kept with dispensed medicines until the items were collected.

Prescriptions for people receiving their medicines in multi-compartment compliance aids were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy routinely contacted people to see if they needed them. The pharmacy kept a record for each patient which included any changes to their medication. There was an audit trail to show who had dispensed and checked each compliance aids. Compliance aids were generally labelled correctly but the backing sheets were not attached to the compliance aids. This could increase the chance of them being misplaced. Cautionary and advisory warning labels were not recorded on the backing sheets. This could make it more difficult for people to know how to take their medicines safely. The SI said that he would contact the patient medication record provider to request that these were recorded on the labels. Medication descriptions were put on the compliance aids. The SI said that patient information leaflets (PILs) were supplied every six months. This could potentially mean that people were not provided with up-to-date information about their medicines. The SI confirmed that he would ensure that these were supplied in future.

CDs were generally stored in accordance with legal requirements and they were generally kept secure. A small number of medicines were not secured in accordance with the legislation and this was rectified during the inspection. The SI said that they would be stored properly in the future. Denaturing kits were available for the safe destruction of CDs. CDs 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 obtain people's signatures for all deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. The driver said that she was planning to implement a system where people signed for their medicines and she would ensure that people's personal information was protected. She said that all deliveries were within the local areas. And if she was unable to deliver a medicine requiring refrigeration she would return this to the pharmacy before continuing her delivery round.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. But no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response. The SI said that he would keep a record of any action taken in future.

The pharmacy did not have the equipment for the EU Falsified Medicines Directive. But the SI said that a new computer system was due to be installed with the equipment within the next few days. He said that team members would be trained on how to use the equipment and an SOP would be written.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Separate measures were marked for CD use only. But the measures were not all clean. The SI said that he would ensure that these were cleaned more frequently and to a higher standard. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

The SI said that the blood pressure monitor had been in use for around year. Most of the testing equipment and lancets in the consultation room had expired. The SI said that these services were not currently offered and he would remove all expired items. The phone in the dispensary was portable so 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.