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: 29/06/2022

Pharmacy context

The pharmacy is located on a busy high street in a largely residential area. It receives most its prescriptions electronically and dispenses several handwritten private prescriptions. It provides a range of services, including dispensing NHS prescriptions and the New Medicine Service. 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. It also supplies substance misuse medications to some people.

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	1.1	Standard not met	The pharmacy does not always manage the risks associated with its services, particularly around the management of its controlled drugs. It has written procedures, but these are not complete. And team members do not always follow them and they are not always familiar with what the procedures are.
		1.6	Standard not met	The pharmacy's records cannot always be relied upon, particularly its controlled drug records. The pharmacy has identified discrepancies in its controlled drug registers but it does not take prompt action to investigate them.
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 not all met	4.3	Standard not met	The pharmacy does not always store its controlled drugs securely. And it does not appropriately control access to its controlled drugs.
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 manage the risks associated with its services, particularly around the management of its controlled drugs. It has written procedures, but these are not complete. And team members do not always follow them and they are not always familiar with what the procedures area. The pharmacy's records cannot always be relied upon, particularly its controlled drug records. It has identified discrepancies in its controlled drugs registers but it does not take prompt action to investigate them. However, the pharmacy adequately manages the other risks involved in its services. It generally protects people's personal information adequately. And people who use the pharmacy can provide feedback about its services. Team members understand their role in protecting vulnerable people. When a mistake happens, team members generally respond well. But they do not routinely record these mistakes, which could mean that they are missing out on opportunities to make the pharmacy's services safer.

Inspector's evidence

There were some documented, up-to-date standard operating procedures (SOPs). But some SOPs were missing, including those to cover 'the arrangements which are to apply during the absence of the responsible pharmacist (RP) from the premises and 'steps to be taken when there is a change of RP at the premises'. Most team members had not signed to show that they had read, understood, and agreed to follow the SOPs. And during the inspection it became evident that some of the SOPs were not always being followed, for example about how to deal with dispensing mistakes. The pharmacist said that he had worked as a locum at the pharmacy for several weeks but he had not read the SOPs.

The pharmacist said that he would highlight to team members if they had made a dispensing mistake which was identified before the medicine had reached a person. He said that team members would usually identify their own mistakes but these were not recorded or reviewed for patterns. The pharmacist printed out a copy of a blank near miss record and said that this would be used in future. The pharmacist was not sure where the pharmacy recorded dispensing errors, where a dispensing mistake had reached a person. He said that he was not aware of any recent dispensing incidents. He said that he would make a record of any dispensing mistakes on the pharmacy's computer system and he would also inform the superintendent (SI) pharmacist. There were SOPs available for near miss recording and dispensing incident reporting, but these were not being followed. There was a form available for team members to record their near misses and this was not being used.

Workspace in the dispensary was free from clutter. And 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. And team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The trainee medicines counter assistant (MCA) knew what she could and should not do if there was no RP. And she knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. However, on a recent visit to the pharmacy, there was no pharmacist in the pharmacy and no RP signed in. And the team were unsure about which tasks they could undertake. The inspector discussed this with them at the time and also informed the SI about the situation.

The right RP notice was clearly displayed and the RP record was largely completed correctly. But there had been an occasion recently where the RP record had not been completed when the pharmacy had been open. The pharmacist said that he would ensure that he completed the record contemporaneously in future. The private prescription records were mostly completed correctly, but the correct prescriber details were not recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. There was a private prescription for a CD which was not written on the correct form. The pharmacist said that he would contact the prescriber. The pharmacist said that he would ensure this issue was addressed and he would also inform the SI so that any prescriptions of this type are dealt with appropriately in the future. The nature of the emergency was not 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. CD registers examined were largely filled in correctly but the address of the supplier was not routinely recorded. The CD balance checks had not been carried out in accordance with the pharmacy's SOPs. The recorded quantity of several CD items checked at random was not the same as the physical amount of stock available. The pharmacist explained that he was in the process of undertaking a full balance check and he had already found a large number of medicines where the balance did not match the physical stock. He said that he had informed the SI around one month ago about these discrepancies, but none of them had been investigated or reconciled. The pharmacy had current professional indemnity and public liability insurance.

The pharmacist was using an NHS smartcard to access the NHS electronic services during the inspection. The smartcard he was using belonged to another pharmacist who had not worked at the pharmacy for several weeks. The pharmacist said that his own smartcard had expired and he had contacted the NHS about this. Another pharmacist's smartcard was also being used by other team members and the personal identification number was displayed on the card. The pharmacist said that he would ask the SI to request smartcards for other team members so that there would be no need to share them. People's personal information on bagged items waiting collection could not be read from the shop area. Confidential waste was shredded at the pharmacy, computers were password protected and the people using the pharmacy could not see information on the computer screens.

The pharmacist was not aware of any patient satisfaction surveys having been carried out since the start of the pandemic. He said that he was not aware of any complaints since he started working at the pharmacy. The pharmacy's complaints procedure was available for team members to follow if needed.

The pharmacist said that he had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. The trainee MCA could describe potential signs that might indicate a safeguarding concern and she said that she would refer any concerns to the pharmacist. The pharmacist said that he was not aware of any recent safeguarding concerns at the pharmacy. There were contact details available at the pharmacy 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 concerns to do with the pharmacy. But the pharmacy does not always address these concerns. So, it may be missing opportunities to improve. Team members do the right training for their roles. But their ongoing training is not very structured, which could make it harder for them to keep their skills and knowledge up to date.

Inspector's evidence

There was one locum pharmacist, one trained dispenser and one trainee MCA working on the day of the inspection. They communicated effectively and worked well together throughout the inspection to ensure that tasks were undertaken in a timely manner. Most team members employed by the pharmacy had completed an accredited course for their role and the rest were undertaking training. But there was no structured ongoing training for team members, which could make it harder for them to keep their knowledge and skills up to date.

The trainee MCA appeared confident when speaking with people. And she was aware of the restrictions on sales of pseudoephedrine-containing products. She explained which medicines had the potential to be abused or may require additional care. And she said that she would refer to the pharmacist if a person asked for more than one packet of these medicines, or if someone wanted to regularly buy these. The trainee MCA questioned people to ensure that the medicine was suitable for them.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he said that he felt able to take professional decisions. He explained how he had noticed that several balances in the CD registers did not match the stock levels in the cabinet. And he had kept a detailed record of all balances that he had checked and written the balance in the register with the amount in the physical stock. He said that he would ensure that the CDAO was informed promptly if the balances could not be reconciled.

The trainee MCA said that she had not had an appraisal or performance review since she started working at the pharmacy around one year ago. She was undertaking a training course for her role and was able to ask for help from the pharmacist or other team members if she was struggling. But there was little evidence that her course progress was being monitored. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said that was able to provide feedback to the SI. Targets were not set for team members.

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 which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a barrier to restrict access from unauthorised people. 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.

There were three 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 to wheelchair users. The room could be accessed from the shop area or the dispensary. The room was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume 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.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store its controlled drugs securely. And it does not appropriately control access to its controlled drugs. So, this means that there is a risk that unauthorised people can access them. Otherwise however, the pharmacy largely provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and mostly stores them properly. People with a range of needs can access the pharmacy's services. The pharmacy does not highlight prescriptions for Schedule 3 and 4 controlled drugs. This could increase the chance of these medicines being supplied when the prescription is no longer valid.

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. One of the dispensers spoke Polish and the trainee MCA spoke Czech Slovakian. The trainee MCA said that there were many people in the local community whose first language was not English and they used this pharmacy as they could speak with these team members. They spoke with many people during the inspection and translated information from the pharmacist.

The prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that he would ensure that these were highlighted in future. So that he had the opportunity to speak with these people. Prescriptions for Schedule 4 CDs were not highlighted. This increased the chance of these medicines being supplied when the prescription was no longer valid. And there was an expired prescription for a Schedule 4 CD waiting collection. The pharmacist said he did not check CDs and fridge items with people when handing them out but said that he would do this in the future. 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 did not have the relevant patient information leaflets available. And it did not have the warning stickers available to attach to white dispensing boxes if needed. The relevant warning cards were on the original boxes and these were supplied with full packs. The dispenser said that she would order an information pack from the medicine manufacturer so that the boxes could be properly labelled and all relevant information could be given to people.

The dispenser said that medicine expiry dates were checked monthly. Items due to expire the following month were removed from dispensing stock and dispose of appropriately. Items were stored in an organised manner in the dispensary. But short-dated items were not marked to help minimise the chance of these medicines being handed out once they had expired. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. ‘Owings’ notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. The pharmacist said that he would request prescriptions for alternate medicines 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. Items remaining uncollected

after around two months were returned to dispensing stock where possible. And the prescriptions for these items were returned to the NHS electronic system or to the prescriber.

The dispenser was not sure if all people who had their medicines in multi-compartment compliance packs had had an assessment carried out to show that they needed their medicines in these packs. She said that she would check with people's GPs and request these if needed. There was an organised way to manage ordering the prescriptions for the packs and these were ordered in advance so that any issues could be addressed before people needed their medicines. The dispenser said that there were other team members who knew how to manage the prescriptions and packs. But she usually assembled them in advance if she was going on planned leave. The pharmacy kept a record for each person which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. But the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. The dispenser said that she would attach the backing sheets in future. Detailed medication descriptions were put on the packs to help people and their carers identify the medicines and the dispenser said that patient information leaflets were routinely supplied.

CDs were not always stored securely. Access to the CDs was not appropriately restricted, and this had also been the case during a recent visit by the inspector. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned were not always recorded in the returns register. There were several medicines returned in 2019 and it was not clear from the record that had been destroyed. As there was no signature recorded to show that this had been done. And the medicines listed as being returned in 2019 were not found in the CD cabinet. There were records to show that previously returned CDs had been destroyed and there were two signatures were recorded. The inspector found a white dispensing box in the CD cabinet with three different CDs inside. There were no medicine details on the box and the pharmacist was not sure if these were part of the dispensing stock or if they had been returned by a patient.

Deliveries were made by delivery drivers. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The delivery driver kept a list of deliveries that they had made and recorded next to the person's details when the items had been delivered or if the person was not home. 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. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not keep a record of the action taken. This could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep an electronic copy of the alert or recall with the action taken in future.

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 and there were separate measures marked for use with certain liquids. 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 shredder was in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

The fridge was suitable for storing medicines and was not overstocked. The dispenser said that another team member was responsible for checking the maximum and minimum temperatures daily. The fridge temperature records could not be located during the inspection and the dispenser was not sure if the temperatures had been checked on the day of the inspection. The current fridge temperature was 5.5 degrees Celsius. The maximum was 8.1 degrees Celsius and the minimum was 5 degrees Celsius. The pharmacist said that he would address this and ensure that the temperatures were checked and recorded daily in future.

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.