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: 19/07/2023

Pharmacy context

The pharmacy is on a busy high street in a largely residential area by the sea. It provides a range of services, including dispensing NHS prescriptions, the New Medicine Service and flu vaccinations. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a large number of people. The pharmacy receives most of its prescriptions electronically.

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. It protects people's personal information. And people can feed back about the service they receive from the pharmacy. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people. The pharmacy doesn't routinely record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). And team members had signed to show that they had read, understood, and agreed to follow them. The pharmacy had not recorded its near misses (where a dispensing mistake had been identified before the medicine had been handed out) for around one year. The pharmacy had previously recorded its mistakes and team members said that they would record them in future. They said that these records would then be reviewed for patterns. The pharmacy was keeping items in similar packaging or with similar names separated where possible to help minimise the chance of the wrong medicine being selected. The superintendent (SI) pharmacist said that he was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. He explained that he would record dispensing errors on the pharmacy's computer and undertake a root cause analysis.

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.

Team members' roles and responsibilities were specified in the SOPs. Team members said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And they knew which tasks should not be undertaken if there was no responsible pharmacist (RP) signed in, or if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP record was completed correctly, and the RP notice was clearly displayed. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's details were not routinely recorded. This could make it harder for the pharmacy to find these details if there was a future query.

The SI said that confidential waste was removed by a specialist waste contractor. 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 awaiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. One of the team said that he would refer any concerns to the SI. And the SI said that there had not been any recent complaints.

Team members had completed training about protecting vulnerable people. They described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The SI 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 trained team members to provide its services safely. They do the right training for their roles, and they do some additional training to help maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. And they can make professional decisions.

Inspector's evidence

There was one pharmacist (who was also the SI) and two trained dispensers working during the inspection. The pharmacy was up to date with its dispensing. And team members worked well together and communicated effectively with each other during the inspection. This helped to ensure that people at the counter were served promptly.

Team members appeared confident when speaking with people. They were aware of the restrictions on sales of pseudoephedrine-containing products. And they said that they would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. They knew which questions to ask people to establish whether the medicines were suitable for the person they were intended for. And they referred queries to the SI throughout the inspection.

The SI said that team members were not provided with ongoing training on a regular basis, but they did receive some on an ad hoc basis. The SI was aware of the continuing professional development requirement for professional revalidation. And he said that he has recently undertaken some training for this. He had also completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to make professional decisions.

Team members explained how they passed on information to each other using a group chat. And there were team meetings held when needed so that they could discuss ongoing issues. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And the SI said that he carried out yearly performance reviews for them. Targets were not set for team member. The SI said that the New Medicine Service was provided for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. And the premises are safe, secure, and clean.

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 chairs in the shop area were positioned away from the medicines counter to help minimise the risk of conversations at the counter being overheard. The consultation room was accessible to wheelchair users. It could be accessed from the shop area and dispensary. It 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 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. And people with a range of needs can access the pharmacy's services. But the pharmacy does not ensure that people who get their medicines in multi-compartment compliance packs always receive all the information they need to take their medicines safely.

Inspector's evidence

Services and opening times were clearly advertised and a variety of health information leaflets was available. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access to the pharmacy through a wide entrance. Team members could produce large-print labels for people who needed them.

The SI said that the pharmacy supplied valproate medicines to a few people. But the pharmacy did not currently supply these medicines to anyone who was in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). He explained that the pharmacy dispensed whole packs of these medicines which ensured that people received all the information they needed to take their medicines safely. And he said that he would refer people to their GP if they needed to be on the PPP and weren't on one. The SI said that team members checked CDs and fridge items with people when these were handed out. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The SI said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin when these were available. But the pharmacy did not keep a record of blood test results. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Team members said that prescriptions were annotated by local surgeries if a person needed a blood test. They said that these messages were passed on to people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were not highlighted. The SI said that these would be highlighted in future to help minimise the chance of these medicines being supplied when the prescription was no longer valid.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. And drug recalls and alerts were received from the NHS and the MHRA. The SI explained how the pharmacy responded to any alerts or recalls. And how the pharmacy kept a record of any action taken.

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 few months were marked and there were no date-expired items found in with dispensing stock. 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 separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and 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.

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. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked monthly. Items remaining uncollected after around one month 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 pharmacy had converted a large room upstairs into a room suitable for assembling and storing the multi-compartment compliance packs. Team members said that this had helped to minimise the distractions and reduced the number of mistakes. The SI said that people had assessments to show that they needed their medicines in the packs. The pharmacy ordered prescriptions in advance so that any issues could be addressed before people needed their medicines. And prescriptions for ‘when required’ medicines were not routinely requested. The SI said that the pharmacy contacted people to see if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled, but there was no audit trail to show who had dispensed and checked each pack. And the backing sheets were not physically attached to the packs. Medication descriptions were put on the packs to help people and their carers identify the medicines. But the patient information leaflets were not routinely supplied. The SI said he would ensure that the packs were suitably labelled, patient information leaflets were routinely supplied, and the backing sheets were attached in future. This would help to ensure that people received all the information they needed.

Deliveries were made by a delivery driver. The pharmacy obtained signatures from people for certain medicines to show that these had been delivered to the right person. The signatures were recorded in a way so that another person’s information was protected. A card was left at the address asking the person to contact the pharmacy to rearrange delivery when the person was not at home. And the items were returned to the pharmacy before the end of the working day.

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

Some suitable equipment for measuring liquids was available. But some were plastic, so the pharmacy would order some suitable replacements. Separate liquid measures were used to measure marked for certain medicines only. 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 blood pressure monitor had been in use for less than one year and it would be replaced in line with the manufacturer's guidance. The weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.