General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Woodlands Pharmacy, Gillingham Medical Centre, Woodlands Road, GILLINGHAM, Kent, ME7 2BU

Pharmacy reference: 1117246

Type of pharmacy: Community

Date of inspection: 19/12/2019

Pharmacy context

The pharmacy is located within a large surgery in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews and the New Medicine 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 provides medicines as part of the Community Pharmacist Consultation Service.

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 protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people. But the pharmacy doesn't always 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 adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs). Team members had signed the SOPs to indicate that these had been read and understood. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were not always recorded, but there had been some recorded until July 2019. The pharmacist said that he would encourage team members to record their own mistakes in the future. And he said that he would review the near miss log regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. A recent dispensing incident had occurred where the wrong strength of medicine had been supplied to a person. The pharmacist said that he was in the process of carrying out the investigation and would complete an incident report form. He had kept the medicine involved so that this could be referred to. The medicines were still kept next to each other, but the pharmacist said that he would separate these to help minimise the chance of a similar mistake.

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. The dispenser said that the pharmacy would open if the pharmacist had not turned up in the morning. He knew that he should not hand out dispensed items or sell pharmacy-only medicines before the pharmacist had arrived, but he thought that he could sell medicines on the General Sales List. And he said that he would carry out dispensing tasks before the pharmacist had arrived. The inspector reminded his what he could and couldn't do if the pharmacist had not turned up. The SOPs stated that dispensing tasks could be carried out when there was no responsible pharmacist signed in. The pharmacy manager said that he would request that the SOP be amended.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The responsible pharmacist (RP) log was completed correctly and the right RP notice was clearly displayed. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records were completed correctly, but there were several prescriptions which had not been entered. The pharmacist said that he would ensure that these were entered in a

timely manner in the future. The pharmacy was using the patient medication record to record emergency supplies, but all of the required information was not recorded. 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. The pharmacist explained that the controlled drug balances were usually carried out at regular intervals. But, a small number of register entries had been missed while he was on leave and the pharmacy had been covered by locums. He was in the process of carrying out a full balance check and said that he was in the process of resolving this. And he would ensure that the required entries were made. Following the inspection, the inspector received confirmation from the pharmacy manager that all of the balances had been reconciled.

Confidential waste was shredded, 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 waiting collection could be viewed by people using the pharmacy, but people's personal information was not visible. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive and showed that nearly 100% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that the pharmacy had recently received a complaint. He explained the steps that had been taken to investigate it and he said that he had informed the superintendent pharmacist.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy. The dispenser 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 trained team members to provide its services safely. They have done the right training for their roles. And they are provided with ongoing training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, three trained dispensers (one was also the pharmacy manager) and one trainee medicines counter assistant (MCA) working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She explained 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. He had recently completed some training about sepsis. The dispenser explained that team members received regular training modules from an external organisation. These were completed during the working day and checked by the pharmacist, but recent copies of the training completed had not been kept. The dispenser said that he would ensure that training records were kept for each member of the team in the future.

The pharmacist said that he felt able to take professional decisions. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. One of the dispensers said that information was passed on informally during the working day. She said that team members had not had appraisals or performance reviews within the last year. The pharmacy manager said that these were due to be carried out soon. Targets were not set for team members. The pharmacist confirmed that he carried out the services for the benefit of the people who used the pharmacy.

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; 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. An entrance to the rear of the dispensary was used when the surgery was closed. There was a separate counter in this area which meant that people did not have access to the dispensary. Air conditioning was available; the room temperature was suitable for storing medicines.

There were several chairs in the waiting area near to the counter and additional seating was available in the surgery. The dispenser confirmed that he would offer the use of the consultation room if a person wanted to discuss something in a more private setting. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The consultation room was accessible to wheelchair users and was located at the rear of the dispensary. It was accessible from the dispensary and the rear entrance to the pharmacy. People using the room could access it from the pharmacy’s waiting area and they did not have to access it through the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the waiting area.

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, so that people get medicines and medical devices that are safe 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 wide entrances. When the surgery was closed and the pharmacy was open, a rear door was used to access the pharmacy. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And checking people's blood test results and keeping a record of these would make it easier for the pharmacy know that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that he would ensure that prescriptions for higher risk medicines and CDs were highlighted in the future. He 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. But it did not have the relevant patient information leaflets or warning cards available. The pharmacist said that he would contact the manufacturer to order replacements.

Stock was stored in an organised manner in the dispensary. The pharmacist said that expiry dates were checked every six months but this activity was not recorded. Short dated stock was not marked. There were several date-expired items found in with dispensing stock and several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. There were several boxes which contained mixed batches found with dispensing stock. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The pharmacist said that he would ensure that a more reliable date-checking routine was implemented. And ensure that medicines were kept in appropriately labelled containers in the future.

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. Part-dispensed prescriptions were kept at the pharmacy until the remainder was dispensed but not until it was collected. The pharmacist said that he would ensure that the prescriptions were kept with the items until collected in the future. Uncollected prescriptions were checked every six weeks. And they were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Uncollected prescriptions were kept at the pharmacy until no longer valid so that they could be re-dispensed if the person came to the pharmacy to collect their medicines.

The pharmacist said that assessments were carried out by the pharmacy or the person's GP for people who received their medicines in multi-compartment compliance packs to show that these were needed. Prescriptions for people receiving their medicines in these 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 dispenser said that people contacted the pharmacy 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 they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacy manager said that he would ensure that these were supplied in the future. Team members wore gloves when handling medicines that were placed in these packs.

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 obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. 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. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But a record of the action taken was not always kept, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep a record in the future.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being used. The pharmacist said that the pharmacy was due to have a different computer system installed in the new year and the pharmacy would start to use the equipment after this.

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 clean. Separate liquid measures were marked for methadone use only. 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 phone in the dispensary was portable so it 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 fridges were 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.