General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Headcorn Pharmacy, Headcorn Surgery, Griggs Lane, Headcorn, ASHFORD, Kent, TN27 9AA

Pharmacy reference: 1121567

Type of pharmacy: Community

Date of inspection: 07/08/2019

Pharmacy context

The pharmacy attached to a GP practice in a large village with around 4000 residents. The people who use the pharmacy are mainly older people. It receives around 80 per cent of its prescriptions electronically. And provides a range of services, including Medicines Use Reviews and the New Medicine Service. The pharmacy provides multi-compartment compliance packs to around 120 people who live in their own homes to help them manage their medicines. And it provides medicines to one residential home with around 12 rooms and one nursing home with around 38 rooms.

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 largely identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And seeks feedback from people who use the pharmacy. It generally keeps its records up to date. And team members understand their role in protecting vulnerable people. They record and review their mistakes so that they can learn and make the services safer.

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), near miss and dispensing incident reporting and review processes.

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 recorded and reviewed regularly for any patterns. Medicines in similar packaging were separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The person noticed the error before taking any of the medicine and the pharmacy supplied the correct medicine. The pharmacist said that the person was satisfied with the way the pharmacy dealt with the incident.

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. A stamp was used on the prescriptions and staff initialled next to the task they had carried out. The pharmacy technician (accuracy checking technician (ACT)) was confident with which prescriptions she could check. She said that she would not check any prescriptions if she had been involved with the dispensing process and she passed any near misses back to the person who had dispensed it for them to change. She recorded all near misses on a log and discussed them with the dispenser at the time.

Team members' roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would not open if the pharmacist had not turned up. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not on the premises. The dispenser thought that she could carry out dispensing tasks if there was no responsible pharmacist (RP). The inspector reminded team members what they could and couldn't do if the pharmacist had not turned up.

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 prescriber's details and date prescribed were not routinely recorded in the private prescription record. Veterinary prescription records did not have the animal's address recorded. 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. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) running balances had been

checked recently. The pharmacist said that the balances had not been checked frequently before he started working at the pharmacy. Liquid methadone balances were checked monthly; overage was recorded in the register. The address of the supplier was not routinely recorded in the CD register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct responsible pharmacist (RP) notice was clearly displayed. But the record was not always completed when the pharmacist finished their shift. The pharmacist said that he would remind pharmacists to complete the log correctly. All necessary information was recorded when a supply of an unlicensed special was made.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected and bagged items waiting collection could not be viewed by people using the pharmacy. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection.

The pharmacy was in the process of carrying out a patient satisfaction survey. Results from the 2017 to 2018 survey were generally positive and these were available on the NHS website. The pharmacist said that he was not aware of any complaints since he started working in the pharmacy around two months ago. The pharmacy had a complaints procedure available and the pharmacy contact details were displayed on the main entrance.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The pharmacist said that he had provided some safeguarding training to other team members when he started working at the pharmacy. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that the delivery driver had reported a potential safeguarding concern to him recently. He said that the person’s GP was already aware of the concerns. 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. The team members can take professional decisions to ensure people taking medicines are safe. They do not have regular meetings, but team members can raise concerns about the pharmacy. They are not always provided with regular ongoing training. This could make it harder for them to keep their skills and knowledge up-to-date.

Inspector's evidence

There was one locum pharmacist, one pharmacy technician (accuracy pharmacy technician (ACT)), two trained dispensers (NVQ level 3), four trained dispensers (NVQ level 2) and two trained MCAs working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. The pharmacy had been without a pharmacy manager for around six months and had been employing locum pharmacists to cover.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. The MCA 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 MCA said that team members used to be provided with ongoing training. But this had not happened for several years.

The MCA said that she used to have yearly performance reviews and appraisals. But she could not remember when the last one was and thought it was more than one year ago. She said that there were no regular pharmacy meetings held. The pharmacist said that a meeting had been arranged so that team members could raise any concerns they had. And the superintendent pharmacist and owners were going to attend the meeting. The pharmacist said that he had made changes since working at the pharmacy and felt supported by the owners and the superintendent pharmacist. He said that he had discussed the staffing levels with them. And he felt able to take professional decisions to help keep people safe.

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.

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

There were four 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 and was located in the shop area. 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 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

The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers and 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.

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 were available.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. 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 and 4 CDs were not highlighted. The MCA knew that prescriptions for Schedule 3 CDs were only valid for 28 days but she was not aware of the validity of prescriptions for Schedule 4 CDs. Dispensed fridge items were kept in clear plastic bags to aid identification. The dispenser 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 valproate patient information leaflets or warning cards available. The dispenser said that she would contact the manufacturer to order some.

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 four months was marked. Short dated stock lists were kept and items were removed around one month before they were due to expire. 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 mixed batches found with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

The dispenser said that part-dispensed prescriptions were checked twice a day. '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. And prescriptions were kept at the pharmacy until the remainder was dispensed. The pharmacist said that uncollected prescriptions were checked around once a month. There were no expired prescriptions found in the retrieval system. But a prescription waiting to be collected had not been signed by the prescriber. The pharmacist removed this and said that he would ensure that the prescription was signed by the prescriber before the medicines were supplied.

Prescriptions for people receiving their medicines in multi-compartment compliance 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 ordered these when needed. The pharmacy kept a record for each person which included any changes to their medication and they also kept 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 and patient information leaflets were routinely supplied. The care homes and residential home ordered prescriptions for their residents. Any prescription queries were dealt with by them.

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; these were recorded in a way so that another person’s information was protected. If 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 patient 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. This made it easier for the pharmacy to show what it had done in response.

The pharmacy did not have the equipment for the implementation of the EU Falsified Medicines Directive. The pharmacist said that he would speak with the superintendent pharmacist to ensure that this was followed up.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it maintains its equipment well.

Inspector's evidence

Suitable equipment for measuring medicines was available. 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 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.

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.