General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Newington Pharmacy, 44 High Street, Newington, SITTINGBOURNE, Kent, ME9 7JL

**Pharmacy reference:** 1121725

**Type of pharmacy:** Community

**Date of inspection:** 25/09/2019

## Pharmacy context

The pharmacy is located on a busy high street surrounded by residential premises. It is opposite a surgery and the people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. It offers Medicines Use Reviews. And it supplies medication in multi-compartment compliance packs to around some people who live in their own homes to help them manage their medicines. The pharmacy provides Post Office services.

## 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 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 not all met | 4.3 | Standard not met | The pharmacy stores medicines in areas where there is a significant risk of unauthorised access. The pharmacy does not adequately separate out-of-date medicines from dispensing stock. |
| **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 largely protects people's personal information and it regularly seeks feedback from people who use the pharmacy. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members are proactive when it comes to protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. Some up-to-date standard operating procedures (SOPs) were available on the day of the inspection. But two required SOPs were not found. Following the inspection, the pharmacist provided the inspector with copies of two of the missing SOPs and provided assurance that he would ensure that all required SOPs were available in future.

The pharmacist said that near misses were highlighted with the team member involved at the time of the incident, and that they identified and rectified their own mistakes. Near misses were not always recorded and there were only a few recorded for 2016 and 2017. The pharmacist said that he would ensure that near misses were recorded and reviewed for patterns. Some items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form. An incident had occurred a couple of years ago where the wrong form of a medicines had been supplied to a person. The incident record did not have a detailed account of all action taken. The pharmacist said that he would carry out a root cause analysis for any future incidents.

Workspace in the dispensary was limited, but 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.

The medicines counter assistant (MCA) said that the pharmacy and Post Office would open if the responsible pharmacist had not turned up. She thought that she could sell general sales list medicines before the pharmacist had arrived. She knew that she should not sell pharmacy only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The inspector reminded her what she 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. All necessary information was recorded when a supply of an unlicensed medicine was made. The date of prescribing and the prescriber's details were not routinely recorded on the private prescription record. There were some hospital prescriptions which did not have all the necessary information on. The pharmacist said that he would ensure that all prescriptions had the necessary information on before dispensing against them. 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) registers examined were mostly filled in correctly, but the address of the supplier was not recorded. The recorded running balance of one CD 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 RP log was not always completed correctly. There were several occasions when the pharmacist had not completed the log when they had started their shift. And several occasions when they had not completed it when they had finished their shift. The pharmacist had not completed the log on the day of the inspection and when prompted, this was not completed to reflect the correct time he had started. The inspector showed him how to complete the log correctly, including how to record absences from the premises. He said that he would ensure that the log was completed correctly in future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist was not using his own smartcard to access the NHS electronic services at the start of the inspection. The card he was using belonged to a team member who was not working at the pharmacy on the day of the inspection. The pharmacist changed the cards over when prompted by the inspector and he said that he would only use his own smartcard in future. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 survey were available on the NHS website. Results were positive overall and 100% of respondents were satisfied with the service provided by the pharmacist. The complaints procedure was available for team members to follow if needed. The pharmacist said that the pharmacy had not received any recent complaints.

The pharmacist and other team members had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Certificates were available in the pharmacy. The MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The team members could give examples of action they had taken in response to safeguarding concerns.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety. They have done the right accredited training for their roles. But 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 pharmacist (who was the owner) and one MCA working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products and was aware of the reason for this. She confirmed 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 had completed an accredited training course for her role. She said that she had requested to be enrolled on a dispenser course and had discussed this with the pharmacist. She confirmed that she had not undertaken any training since completing the course around two and a half years ago. The pharmacist was aware of the Continuing Professional Development (CPD) requirement for the professional revalidation process. He said that he would complete CPD on the Falsified Medicines Directive (FMD) and valproate medicines.

The MCA said that she received informal ongoing appraisals and performance reviews, but these were not documented. She said that she felt comfortable about discussing any concerns or issues with the pharmacist. Targets were not set for team members. The pharmacist said that he provided services for the benefit of people who used the pharmacy.

## Principle 3 - Premises ✔ Standards met

### Summary findings

Overall, the premises provide a secure and clean environment for the pharmacy's services.

### Inspector's evidence

The pharmacy was secured from unauthorised access. 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; the room temperature was suitable for storing medicines.

There were two chairs in the shop area. These were positioned near the medicines counter so conversations at the counter could clearly be heard. The pharmacist said that he offered the use of the consultation room if people wished to discuss something in a more private setting.

The pharmacy's consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area.

The pharmacist said that the cellar used to be used to assemble multi-compartment compliance packs, but there was a problem with damp and packs were no longer assembled here. Some medicines were kept in the rooms downstairs. A de-humidifier was in use on the day of the inspection. The pharmacist said that he was in the process of addressing the issue with the damp.

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 generally manages its services well. But the pharmacy does not always ensure that its medicines are secured from unauthorised access. And it doesn't use robust procedures to date-check its medicines. It gets its medicines from reputable suppliers and stores most of them properly. It responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. 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 a wide entrance. It was not obvious how to open the main door to the pharmacy. There was a small notice at the door indicating that it had to be slid to open. The pharmacist said that he would display a more prominent notice. There was a bell at a suitable height for wheelchair users and a notice asking them to press for assistance. 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. The MCA said that a person had shown her a bite on their ankle and the pharmacist was not in the pharmacy at the time. She said that she had referred the person to a local walk-in centre to be seen by a nurse or doctor. She was aware of which local hospitals could provide the different services.

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 did not check people's 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. The pharmacist was unsure about the requirements to provide warning cards and patient information leaflets to people in the at-risk group taking valproate medicines. He said that there was only one person who regularly had this medicine from the pharmacy and they were not in the at-risk group. The pharmacy did not have the patient information leaflets or warning cards available. The pharmacist said that he would order some from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked infrequently and this activity was only sometimes recorded. Short-dated items were not marked. There were several expired items and boxes containing mixed batches found in with dispensing stock. This could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. One item found had expired in March 2019. A box of tablets found did not have the expiry date or batch number on it and the foil strip inside did not have the expiry date recorded. The pharmacist said that he would dispose of these medicines appropriately. There was a large amount of expired medicines in baskets on the floor in the dispensary next to in-date medicines. It was not clear which medicines had expired and there was a risk that date-expired medicines could become mixed up with in-date stock.

The pharmacist said that part-dispensed prescriptions were checked daily. He said that 'owings' notes used to be provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. But this had been recently stopped. He said that he would start supplying them again. Prescriptions for alternate medicines were requested from prescribers where needed.

Prescriptions were not kept at the pharmacy until the remainder was dispensed. This could make it harder for team members to refer to the original prescription and could potentially increase the chance of errors.

Uncollected prescriptions were checked regularly. The pharmacist said that uncollected prescriptions were checked regularly and uncollected items were returned to dispensing stock where possible. Prescriptions for Schedule 3 and 4 CDs were not highlighted, and prescriptions were not kept with dispensed medicines until they were collected. This could make it harder for the pharmacy to confirm that the prescription was still valid at the time of supply.

The pharmacist said that he referred people to their GP if he thought that they may benefit from having their medicines dispensed into multi-compartment compliance packs. He said that assessments were completed at the pharmacy and sent to the person's GP. Prescriptions for some 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 contacted the pharmacy when they needed them. 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. Medication descriptions were put on the packs to help people and their carers identify the medicines. Patient information leaflets were not routinely supplied. This could make it harder for people have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that these were supplied to people in future.

CDs were stored in accordance with legal requirements. 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 at the time of destruction and destroyed with a witness; two signatures were recorded. The door to the consultation room was not lockable and there were unsecured items in the room.

Deliveries were made by a delivery driver. The pharmacy occasionally obtained people's signatures for deliveries. This could make it harder for the pharmacy to show that the medicines were safely delivered. When signatures were obtained, they were not recorded in a way so that another person's information was protected. The pharmacist said that he would ensure that signatures were routinely obtained and people's personal information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. The pharmacist confirmed that medicines were posted through letterboxes with verbal permission from people. He said that he would implement a more formal risk assessment and consent form for this process instead.

The pharmacy used licensed wholesalers to obtain 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 pharmacist said that he would keep an audit trail for future reference.

The pharmacy did not have the equipment to be able to comply with the EU Falsified Medicines Directive. The pharmacist did not know where to order the equipment from, but he said that he would check.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy largely had 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. Triangle tablet counters were available and clean. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle.

Up-to-date reference sources were available in the pharmacy and online. The manual shredder was 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. |