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: 18/08/2020

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 and it offers Medicines Use Reviews. It supplies medication in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. The pharmacy also provides Post Office services. The inspection was carried out during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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, pharmacy identifies and manages the risks associated with its services adequately. It protects people's personal information and people can provide feedback about the pharmacy. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. But it doesn't always complete the responsible pharmacist record or make entries in some other records in a timely manner. And this means that these records could be less reliable if there was a query.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with pharmacy activities. Up-to-date standard operating procedures (SOPs) were available on the day of the inspection. The pharmacist said that workplace risk assessments had been carried out recently. The pharmacist said that dispensing mistakes which were identified in the pharmacy before the medicine was handed out (near misses) were highlighted with the team member involved at the time of the incident. And that they identified and rectified their own mistakes. He said that as the pharmacy had been very busy due to the ongoing pandemic and team members had not had time to record and review any near misses. 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 mistakes where the medicine had reached the person (dispensing errors) were recorded on a designated form. The pharmacist said that he was not aware of any recent dispensing errors.

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 dispenser said that the pharmacy and Post Office would open if the pharmacist had not turned up. She knew that she should not sell any medicines before the pharmacist had arrived. And she knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

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 prescriber's details were not routinely recorded on the private prescription record. The nature of the emergency was not usually 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 and the recipient was not usually recorded. And entries were not always made in a timely manner. Following the inspection, the pharmacist confirmed that the entries in the register were all up to date.

The correct responsible pharmacist (RP) notice was clearly displayed, but the RP record was not always completed correctly. There were several occasions when the pharmacist had not completed the record when they had started their shift. The pharmacist had not completed the record on the day of the

inspection but he completed this when prompted. The inspector showed him again how to complete the record correctly, including how to record absences from the premises. The same issues with the RP record had been noted in the previous inspection by the inspector and had been discussed with the same pharmacist. The pharmacist said that he would ensure that the record was completed correctly in future. The RP record had been completed correctly on those days when a locum pharmacist had been working at the pharmacy.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Team members used their own smartcards to access the NHS electronic services. Bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacy carried out patient satisfaction surveys and the latest results available on the NHS website were from the 2018 survey. 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. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She said that she was not aware of any recent 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 qualified dispenser working during the inspection. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The dispenser 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 dispenser had completed an accredited training course for her role. She confirmed that she had not undertaken any training recently. She said that the pharmacist passed on information informally during the working day. The pharmacist was aware of the Continuing Professional Development (CPD) requirement for the professional revalidation process.

The dispenser 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

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.

The pharmacy had a sign asking that a maximum of four people were in the pharmacy shop area at a time. 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. 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 met

Summary findings

The pharmacy generally manages its services well. And people with a range of needs can access them. It gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. 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. 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 pharmacist said that said that he usually highlighted dispensing bags with Schedule 3 and 4 CDs in. None were found during the inspection, so this could not be checked. 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. 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. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that the pharmacy had received some updated valproate warning cards and patient information leaflets. And he would give these people in the at-risk group if needed. He said that there were only a few people who regularly had this medicine from the pharmacy and they were not in the at-risk group.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked frequently, but this activity had not been recorded recently. Short-dated items were not marked. There were no date-expired items found with dispensing stock. A dispensing bottle labelled as paracetamol did not have the expiry date or batch number of the medicine on it. The pharmacist said that he would dispose of this medicine appropriately and ensure that medicines were kept in appropriately labelled containers in the future.

The pharmacist said that part-dispensed prescriptions were checked regularly. 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 issuing owings notes 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 always 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. The pharmacist said that uncollected prescriptions were checked regularly, and uncollected items were returned to dispensing stock where possible.

The pharmacist said that he carried out assessments for people who might benefit from having their medicines dispensed into multi-compartment compliance packs. And he said that a copy of the assessment was 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 with their packs. 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. And patient information leaflets were routinely supplied.

CDs were stored in a suitable cabinet. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept separate. Returned CDs were recorded in a register at the time of destruction and destroyed with a witness, with two signatures recorded.

Deliveries were made by a delivery driver. The dispenser said that the driver was not asking for signatures from people due to the risk of Covid-19. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. But a record of any 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 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 asked the inspector where he needed to order the equipment from. He had asked this during a previous inspection. The pharmacist said that he would contact the MHRA for guidance.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy 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. Team members wore face coverings while in the pharmacy and alcohol gel was available.

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.

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.