General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitecliffs Pharmacy, 141 Folkestone Road, Dover, Kent, CT17 9SG

Pharmacy reference: 9010119

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

The pharmacy is located within a supermarket and next to a surgery. It is close to the port of Dover and is surrounded by residential premises. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, INR testing and warfarin supplies, a travel clinic and influenza vaccinations. It supplies medications in multi-compartment compliance packs to a few people who live in their own homes to help them manage their medicines.

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 regularly seeks feedback from people who use the pharmacy and it largely protects people's personal information. It generally 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.

Inspector's evidence

The pharmacy adopted an adequate range of measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs). Team members had signed to indicated that they had read and understood them. 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 sometimes recorded, but the dispenser confirmed that this was not always done. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser said that the pharmacy had received a list of medicines which had similar names from one of their suppliers. Team members had used this to separate some items. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person has returned the medicine to the pharmacy and the correct item was dispensed. The medicines were now kept separated in the drawer 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 remain closed if the pharmacist had not turned up and she would contact the superintendent (SI) pharmacist to inform him. And she confirmed that she would not sell any 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 private prescription records were mostly completed correctly, but the date on the prescription was not recorded. There were several private prescriptions dispensed in October 2019 that had not yet been entered in the register. The dispenser said that they would ensure that these were recorded in a timely manner in future. 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. There were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were largely filled in correctly. But the address of the supplier was not always recorded. There were alterations made to CD records, but there was no audit trail to show when these

changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query. The CD running balances were checked at regular intervals, and the recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The responsible pharmacist (RP) log was largely completed correctly and the correct RP notice was clearly displayed.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Two smartcards used to access the NHS spine were in the docking stations at the start of the inspection. These belonged to team members who weren't in the pharmacy at the start of the inspection. The SI changed to using his own smartcard when prompted. He said that he knew the personal identification number for one of the team members smartcards but would ensure that this was changed. And he would ensure that team members secured their own cards when these were not in use. 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 to 2019 survey were available on the NHS website. Results were positive and over 99% of the people who responded were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed. The SI said that there had not been any recent complaints. Some people who used the pharmacy during the inspection made compliments about team members.

The SI had completed the Centre for Pharmacy Postgraduate Education (CPPE) 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 SI said that there had not been any safeguarding concerns at the pharmacy. And 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 can raise any concerns or make suggestions. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. 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 and two trained dispensers working during the inspection. Team members had completed an accredited course for their role. They wore smart uniforms and 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 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. She explained that some people had been referred to their GP when they had requested to purchase some over the counter medicines which they already had on prescription. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The SI was aware of the Continuing Professional Development requirement for the professional revalidation process. And he had recently carried out some training on CBD oil. He had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to take professional decisions. He said that team members were not provided with ongoing training on a regular basis. But they did receive some, such as product information. He said that he did not keep records for any training completed, but would consider this. One of the dispensers said that she had been enrolled on an NVQ level 3 pharmacy course. She explained that she had access to CPPE modules online and she passed on information that she had learnt on her course to other team members. She had recently learnt about a product which was potentially not suitable for taking when pregnant and she had let other team members know.

Team members felt comfortable about discussing any issues with the SI or making any suggestions. Team members were recently allowed to choose their new uniform. The dispenser said that there were informal huddles to discuss any issues or concerns. And that team members had informal ongoing performance reviews but these were not documented.

Targets were set for Medicines Use Reviews and the New Medicine Service. The dispenser said that the pharmacy provided services for the benefit of people who used the pharmacy and only when needed.

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

The consultation room was accessible to wheelchair users and was accessible from the shop area and dispensary. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. There were three 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. Additional seating was available in the surgery next door.

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. It 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 with an automatic door. Services and opening times were clearly advertised and a variety of health information leaflets was available. The induction hearing loop appeared to be in good working order. The SI managed the services, including the warfarin supplies and travel vaccinations. Information about vaccinations administered to people was recorded on the online CityDoc reporting system.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. He offered an INR clinic to test people's blood before making supplies of warfarin. He was independent prescriber and wrote prescriptions before supplies were made. An appointment system was used so that people attended the clinic when he was working. Results were recorded on INR Star. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected any higher-risk medicines. The dispenser said that team members checked when people had last had a blood test when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This may increase the chance of these medicines being handed out when the prescription was no longer valid. A prescription dated 23 August 2019 for a Schedule 4 CD was waiting collection. The SI said that he would ensure that these were highlighted in future. The dispenser said that the pharmacy supplied valproate medicines to a few people. And there was one person in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacist said that he had ensured that the person was aware of the risks with taking their medicine. The pharmacy had the relevant patient information leaflets and warning cards available and the SI said that these were handed out when needed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked at regular intervals and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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. Prescriptions were kept at the pharmacy until the remainder was dispensed, but not until they were collected. This could make it harder for team members to refer to the original prescription when handing out. The SI said he would ensure that a copy of the prescription was kept in future. Uncollected prescriptions were checked regularly and prescriptions which were left uncollected after around three months were returned to the NHS electronic system or to the prescriber. And the items were returned to dispensing stock where possible. The pharmacy kept a list of prescriptions which had not been collected so that the person could be informed if they came to collect their medicine.

The dispenser said that people were referred to their GP for an assessment before they had their medicines dispensed into multi-compartment compliance packs to show that they needed them. 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 the pharmacy contacted people to see if they needed them when their packs were due each month. 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. But the additional warnings and cautionary advisory labels were not on the backing sheets. The dispenser said that she had contacted the software provider before to request that these be added. She confirmed that she would contact them again. 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 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. But there were multiple people's details on each sheet so the layout might make it harder to ensure that people's details were protected when signatures were recorded. The pharmacist said that he would ensure that other people's personal information was protected when signatures were recorded in future. 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. 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 dispenser said that she would keep an audit trail on the email system to show what action had been taken.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that all team members had undertaken some training on how the system worked and written instructions were available for the processes. He confirmed that the equipment would be used fully in the near future.

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. A triangle tablet counter was marked for methotrexate use only and it was clean. This helped avoid any cross-contamination. An electronic tablet counter was available but this was coated in a layer of powder residue. The dispenser said that she had told other team members not to use it and she instead used a small tray when counting tablets or capsules. She confirmed that the electronic counter would be removed from the dispensary and not used in future.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around two years and it was due to be replaced. The SI said that most people who used the pharmacy had their blood pressure checked at the surgery next door when needed. The shredder was in good working order. The testing equipment used for the INR service was regularly calibrated. 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.