General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Barnehurst Pharmacy, 87 Barnehurst Road, Bexleyheath, DA7 6HD

Pharmacy reference: 9010324

Type of pharmacy: Community

Date of inspection: 06/07/2022

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area near Barnehurst train station. It provides a range of services, including the New Medicine Service and the flu vaccination service (seasonal). And it supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines.

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, the pharmacy identifies and manages the risks associated with its services to help provide them safely. Team members take appropriate action to ensure that vulnerable people are safeguarded. They record and regularly review mistakes that happen during the dispensing process. And the pharmacy uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information well. And people can feedback about the pharmacy's services. And the pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy has measures for identifying and managing risks associated with its activities. The pharmacist explained that the superintendent (SI) pharmacist was in the process of updating the pharmacy's standard operating procedures (SOPs). And these were not available at the pharmacy on the day of the inspection. Following the inspection, the SI provided the inspector with a sample of the SOPs, along with a full list of the ones that the pharmacy had available.

Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members explained how they identified and rectified their own mistakes. And the near misses were recorded and reviewed 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. The pharmacist explained how she would record any dispensing errors, where a dispensing mistake had reached a person. She said that a root cause analysis would be undertaken and the SI would be informed. The pharmacist was not aware of any recent dispensing errors.

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.

The dispenser explained the process she would follow if the pharmacist had not turned up in the morning. And she said that the pharmacy would not open if there was only one member of staff. A notice would be displayed at the entrance to the pharmacy informing people that there was no pharmacist available. And she said that she would attempt to contact the pharmacist and the SI. She was unsure of some of the tasks that she should not carry out if there was no responsible pharmacist (RP) signed in. But she knew that she should not hand out dispensed items or sell pharmacy-only medicines if the RP was not in the pharmacy. The inspector reminded her about what team members could and could not do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked

at random was the same as the physical amount of stock available. The right RP notice was clearly displayed and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query.

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 electronic services were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be read by people using the pharmacy. And team members had completed training about data protection.

The pharmacy had carried out a carried out a patient satisfaction survey for 2021 to 2022. And there had been some positive feedback received from people who had used the pharmacy's services. The pharmacist was not aware of any recent complaints. And the pharmacy's complaints procedure was available for team members to follow if needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy. The delivery driver could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist gave an example of action she had taken in response to recent safeguarding concerns. She had emailed a person's GP to make them aware of her concern. The person now received their medicines in a multi-compartment compliance pack to help them take their medicines. And the pharmacist explained about another occasion where the delivery driver had made her aware about a concern he had about a person that the pharmacy delivered medicines to. And checks had been made to ensure that the person was receiving the care that they needed. 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 do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was one full-time pharmacist and one trained dispenser working during the inspection. Team members had completed an accredited course for their role. The workload was well managed and the team worked well together and communicated effectively to ensure that tasks were prioritised.

The dispenser appeared confident when speaking with people. She asked relevant questions before selling a medicine to ensure that it was suitable for the person. She was aware of the restrictions on sales of pseudoephedrine containing products. And 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.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She explained the recent training she had undertaken. And it included optimising inhaler technique, health inequalities and the NHS Discharge Medicines Service. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. She explained that she passed on relevant information to them during the day. And she said that team members read the monthly health living leaflets and answered the questions. But a record was not kept showing that this had been done.

The pharmacist said that she could take professional decisions. And she felt confident about discussing any issues with the SI as they arose. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They received ongoing informal appraisals from the pharmacist, but these were not documented.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. And 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 which presented a professional image. Pharmacy-only medicines were kept behind clear screens in the shop area. And ‘please ask for assistance’ was displayed on the screens. There was a clear view of the medicines counter from the pharmacist's checking area. She could clearly hear conversations at the counter and intervened when needed during the inspection. Air conditioning was available and the room temperature was suitable for storing medicines.

There were two chairs in the shop area and both had arms to aid standing. 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 next to the medicines counter. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And 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. The pharmacy gets its medicines from reputable suppliers and 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. It dispenses medicines into multi-compartment compliance packs safely. But the pharmacy does not 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 with a power-assisted door. 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 she 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 routinely 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. This could increase the chance of these medicines being supplied when the prescription is no longer valid. There was one prescription found waiting collection that had expired a couple of days before the day of the inspection. The pharmacist removed this from the retrieval area. The pharmacist 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 had the relevant patient information leaflets, warning cards available and warning stickers available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly and this activity was recorded. Stock due to expire within the next three months were 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 and collected. The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around one month. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. 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. The pharmacist said that people contacted the pharmacy if they did not need their ‘when required’ medicines 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. Detailed 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, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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. A copy was kept on the pharmacy's email system, but the action the pharmacy had taken was not recorded. This could make it harder for the pharmacy to show what it had done in response. The pharmacist said that she would keep a record of the action taken in 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. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

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 with maximum and minimum temperatures 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.