General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Austinoma Chemist Ltd, Green Porch House, Green Porch Close, Sittingbourne, Kent, ME10 2HA

Pharmacy reference: 9011491

Type of pharmacy: Community

Date of inspection: 15/02/2022

Pharmacy context

The pharmacy is located next to Green Porch doctor's surgery in a largely residential area. And it serves a population with a wide variety of ages. The pharmacy receives around 90% of its prescriptions electronically. And it provides a range of services, including the New Medicine Service and flu vaccinations. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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 largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information. People who use the pharmacy can provide feedback about its services. Team members understand their role in protecting vulnerable people. When a mistake happens, the team generally responds well. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy adopted adequate 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 show that they had read, understood, and agreed to follow the SOPs. The pharmacy had carried out workplace risk assessments in relation to Covid-19. 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 identified and rectified their own mistakes. Some near misses had been recorded by one member of the team, but another team members had not been recording theirs. They said that they would record them in the future. The inspector discussed with the pharmacist the benefits of reviewing the near miss records. This may help the pharmacy to identify patterns and help minimise the chance of mistakes. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong type of medicine had been supplied to a person. An incident report form had been completed and the medicines had been separated.

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. 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 trainee dispenser knew which tasks she could and should not carry out if the pharmacist was not in the pharmacy. She referred to the pharmacist throughout the inspection where needed.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. 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. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But the RPs had not completed the record when they ceased to be RP. Controlled drug (CD) registers examined were filled in correctly and

any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. The pharmacist used her own smartcard to access the NHS electronic services. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacist had completed training about the General Data Protection Regulation and the trainee dispenser said that she had undertaken some training about data protection.

The pharmacist said that the pharmacy planned to carry out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out since moving to the new premises. The complaints procedure was available for team members to follow if needed and details about it were available in the shop area. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The pharmacist said that the trainee dispenser had not received any formal safeguarding training, but she knew to refer any concerns to the pharmacist on duty. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. 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 team members to provide its services safely. Staff are provided with some training to support their learning needs and develop their skills. They can raise any concerns or make suggestions. Team members can take professional decisions to ensure people taking medicines are safe. They do the right training for their roles. But the pharmacy does not always ensure that team members are enrolled on relevant courses within the required timeframe.

Inspector's evidence

There was one pharmacist and one trainee 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 trainee dispenser had been working at the pharmacy for just over three months, but she had not been enrolled on an accredited course for her role. The inspector discussed with the pharmacist and trainee dispenser about the time requirements for staff to be enrolled on an accredited course. The pharmacist said that the trainee dispenser had only just finished her probationary period and that she would be enrolled on a suitable course as soon as possible. Following the inspection, the superintendent pharmacist (SI) sent the inspector confirmation showing that the trainee dispenser had been enrolled on an appropriate course. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

The trainee dispenser appeared confident when speaking with people. Effective questioning techniques were used to establish whether the medicines were suitable for the person. And the trainee dispenser referred to the pharmacist when someone asked to buy a pharmacy-only medicine. And she passed the relevant information to the pharmacist. The trainee dispenser 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 recent training she had undertaken, which included the influenza vaccination refresher training. She told how she read pharmacy-related magazines to help keep her knowledge up to date. The pharmacist felt able to take professional decisions. And she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The trainee dispenser felt comfortable about discussing any issues with the pharmacist or making any suggestions. She explained that she had been receiving ongoing informal appraisals since starting at the pharmacy. She said that tasks were allocated to her each morning, and the pharmacist monitored her progress. Targets were not set for team members. The pharmacist said that she provided the services for the benefit of people using the pharmacy. The pharmacist was married to the superintendent (SI) pharmacist and he attended the pharmacy during the inspection. The pharmacist said that the SI was in regular contact with the pharmacy and that he promptly addressed any concerns raised.

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. And this presented a professional image. Pharmacy-only medicines were kept behind the counter, but some were in an area where people using the pharmacy could pick them up. The pharmacist said that she would move these medicines. 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, and the room temperature was suitable for storing medicines.

The shop area was large enough so that people could maintain a suitable distance from each other. There was one chair in the shop area for people to use while waiting. It was 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 down a corridor to the rear of the pharmacy. It was suitably equipped and conversations at a normal level of volume in the consultation room could not be heard from the shop area. The room had a window. The pharmacist said that this would be covered in the future to ensure that people’s dignity was protected while using the room. Not all items in the room were stored securely, and the pharmacist gave assurances that this would be addressed. 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. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and generally 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. And it dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with an automatically opening 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 if people taking higher-risk medicines such as methotrexate and warfarin were having the relevant blood tests done at appropriate intervals. But a record of blood test results was not kept at the pharmacy. This could make it harder for the pharmacy to check that the person was having the regular tests. The pharmacist said that these medicines were handed out by the pharmacist only, so there was the opportunity to speak with these people when they collected their medicines. 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. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. But the pharmacist said that 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 relevant patient information booklets or additional warning cards available. The warning cards were attached to the boxes. The pharmacist said that she would order more cards from the manufacturer, so that these could be supplied to people when needed.

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 six months was marked. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked regularly. '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. Uncollected prescriptions were not checked regularly, and a copy of the prescription was not kept with dispensed items until they were collected. This could make it harder for team members to refer to the original prescription and could potentially increase the medicine being handed out when the prescription was no longer valid. There were some items waiting collection and the original prescriptions were no longer valid. The pharmacist said that she would implement a more reliable system to ensure that items were removed from the retrieval system promptly. And she said that prescriptions would be kept with the dispensed items until people came to collect their medicines.

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. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people usually contacted their surgery if they needed them 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. Patient information leaflets were routinely supplied, and this helped to make it easier for people to have up-to-date information about how to take their medicines safely.

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.

Fridge temperatures were not routinely checked. The fridge temperature on the day of the inspection was 3.3 degrees Celsius, which was within the appropriate range. But the maximum was showing as 13.9 degrees Celsius. The pharmacist said that the fridge temperatures would be checked daily in future. The fridge was suitable for storing medicines and was not overstocked.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. This made it easier for the pharmacy to show that the medicines were delivered. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And 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. 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.

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. Separate liquid measures were used to measure 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. Implements 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 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. There were masks, gloves, and hand sanitiser available for team members to use to help minimise the spread of infection.

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.