General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: College Pharmacy, 87 Riverside Estate, Sir Thomas Longley Road, Rochester, Kent, ME2 4BH

Pharmacy reference: 9011541

Type of pharmacy: Internet / distance selling

Date of inspection: 23/06/2021

Pharmacy context

The pharmacy is on an industrial estate near Rochester town centre. And it provides most of its services at a distance, but people can access the pharmacy for some private services (travel clinic, allergy testing, period delay and erectile dysfunction). The people who use the pharmacy are mainly older people. The pharmacy receives around 90% of its prescriptions electronically. And it provides a range of services, including the New Medicine Service and the Discharge Medicines Service. It also provides PCR test kits for Covid-19. The pharmacy supplies medications in multi-compartment compliance packs to many people to help them manage their medicines. It also provides medicines as part of the Community Pharmacist Consultation Service. 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	2.2	Good practice	Team members are given time set aside to undertake regular and structured training. This helps them keep their knowledge and skills up to date.
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

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information. And people are able to provide feedback about the pharmacy's services. It keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

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), and reporting and reviewing of dispensing mistakes. 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. And the pharmacist superintendent confirmed that risk assessments had been undertaken to ensure that its services at a distance were done safely.

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. And the pharmacist recorded the near misses and these were reviewed regularly for any patterns. The outcomes from the reviews were discussed openly with the team. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. A member of the team had selected the wrong medicine on several occasions. The medicines had been separated onto different shelves to help minimise the chance of the same mistake happening.

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. The different types of medicine had already been separated onto different shelves in the pharmacy. The pharmacist was in the process of reviewing how prescriptions for these medicines were dispensed to help minimise the chance of a similar error.

Workspace in the dispensary was free from clutter and the dispensing and checking processes were well organised. This helped team members 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 knew which tasks she should not undertake if there was no responsible pharmacist (RP). And she knew that the pharmacist must be on the premises for her to hand dispensed items to the pharmacy's delivery driver.

The pharmacy had current professional indemnity and public liability insurance. The pharmacy had not

made any supplies of an unlicensed medicine. The pharmacist explained the information she would record when a supply of an unlicensed medicine was made. The private prescription records were completed correctly. 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. There were signed in-date patient group directions available for the relevant services offered. 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 largely completed correctly. But the pharmacists did not always complete the RP record when they finished their shift. The pharmacist said that she would ensure that the RP record was completed in future.

Confidential waste was shredded in the pharmacy, computers were password protected and there was no patient information visible to people accessing the pharmacy's consultation room. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting to be delivered were kept in lockable units and the pharmacist said that these would be closed while people were accessing the pharmacy for the private services. Team members had completed training about protecting people's personal information.

The pharmacy had carried out yearly patient satisfaction surveys before it relocated, but because of the pandemic it had not carried one out for 2020 to 2021. The complaints procedure was available for team members to follow if needed and details about it were available online. The pharmacist said that there had not been any recent complaints.

The pharmacist and dispenser had completed the Centre for Pharmacy Postgraduate Education (level 2) 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. The pharmacist explained a recent safeguarding concern and the action the pharmacy had taken in response. 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. And they get time set aside in work to complete it. They are able to raise any concerns or make suggestions. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist (who was the SI) and one trained dispenser (NVQ level 3 apprentice) working during the inspection. A student on work experience was at the pharmacy and they were reading about data protection during the inspection. The pharmacist explained to the dispenser that the student would be shadowing her once she had finished completed the necessary confidentiality declaration. Most team members had completed an accredited course for their role and the rest were undertaking training. The dispenser and pharmacist 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 over the phone. And she referred to the pharmacist during the inspection where needed. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had recently completed the pharmacist independent prescriber course and was planning to spend more time in a GP surgery before offering a prescribing service at the pharmacy. She said that she had specialised in musculoskeletal conditions. The pharmacist had also undertaken recent training about the Community Pharmacist Consultation Service, the Discharge Medicines Service and sepsis. She also read pharmacy-related magazines and passed on relevant information from these to the team. The pharmacist felt able to take professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

The team had access to online training courses and had protected training time so that these could be completed while at work. Team members had an individual training folder containing certificates of completed training. The pharmacist monitored the training and encouraged team members to undertake a variety of courses. One of the dispensers was in the process of completing the Health Living Pharmacy course.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist said that team members usually had informal appraisals and performance reviews annually. But these were not currently documented. The dispenser said that she had monthly reviews with the pharmacist as part of her apprentice pharmacy course, and these were documented. She also had phone calls with her tutor around once a week to ensure that she was on track with her learning. Targets were not set for team members for the pharmacy's services.

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

The consultation room was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the dispensary. 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

People with a range of needs can access the pharmacy's services. The pharmacy provides its services safely and manages them well. And it dispenses medicines into multi-compartment compliance packs safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

Services and opening times were clearly advertised at the main entrance to the pharmacy and on the pharmacy's website. The pharmacy's contact details were on its website. Access to the main dispensary area was via an internal staircase. The pharmacist explained that if someone wanted to access the pharmacy's services and they were not able to walk up the stairs, an office was available downstairs. The office was accessible to wheelchair users. The pharmacy could generate large print labels if needed. The pharmacist explained that the pharmacy supplied PCR test kits to some people. The inspector discussed that the pharmacy may need to accreditation from UKAS if it was taking part in certain aspects of the service. The pharmacist said that she would contact UKAS to check if accreditation was needed.

The pharmacist said that she regularly contacted people taking higher-risk medicines such as methotrexate and warfarin, to confirm that they had recent blood tests. Results were noted on the person's medication record. This made it easier for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said the delivery driver checked CDs and fridge items with people when delivering them. 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 and warning cards available. The pharmacist confirmed that these would be supplied to all females every time the medicine was dispensed.

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

There were no part-dispensed prescriptions at the pharmacy on the day of the inspection. The pharmacist said that 'owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. And prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and delivered.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in 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. People contacted the pharmacy 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. 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 delivery driver left a copy of the delivery sheet at the pharmacy so that the pharmacy knew which items were out for delivery and could inform people if they contacted the pharmacy.

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 and triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only, which 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. And the dispenser said that she wore gloves when dispensing medicines into the multi-compartment compliance packs. Team members wore masks while at work, and hand sanitiser was available.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for fewer than six months. The pharmacist said that this would be replaced in line with the manufacturer's recommendations. 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.