General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pharmacy 1st Ltd, 186-188 Canterbury Street, Gillingham, Kent, ME7 5XG

Pharmacy reference: 9011572

Type of pharmacy: Community

Date of inspection: 15/06/2021

Pharmacy context

The pharmacy is in a largely residential area on a main road near Gillingham high street. The people who use the pharmacy are mainly older people. The pharmacy receives around 85% of its prescriptions electronically. It provides a range of services including the New Medicine Service. And it also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of 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

The pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And it protects people's personal information. Team members understand their role in protecting vulnerable people. And people are able to provide feedback about the pharmacy's services. 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 adopted adequate measures for identifying and managing risks associated with its activities. It had carried out workplace risk assessments in relation to Covid-19. There were up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood and agreed to follow the SOPs. 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. 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 pharmacy technician said that the shelf edges were due to be marked to highlight medicines with similar names or in similar packaging to help minimise the risk of the wrong medicine being selected. He said that this had not yet been carried out due to the recent relocation. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacy technician said that there had not been any recent errors reported to the pharmacy.

There was ample workspace in the dispensary and it was free from clutter. An organised workflow helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Multi-compartment compliance packs were assembled in a separate area from where other prescriptions were dispensed and checked. And this helped to minimise distractions. 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 pharmacy manager said that he would contact the pharmacy's head office if the pharmacist had not turned up in the morning. He was aware of what tasks should not be carried out if there was no responsible pharmacist (RP). And he would not sell any pharmacy-only medicines or hand out dispensed items if the RP was absent from the premises.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed and the RP record was 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. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not usually recorded. The CD running balances were checked at regular intervals 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. The pharmacy technician explained that all necessary information was recorded when a supply of an unlicensed medicine was made. The folder was in a locked office and not accessible during the inspection. The private prescription records were largely completed correctly, but the prescriber's details were not usually recorded. This could make it harder for the pharmacy to find these details if there was a future query.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about protecting people's information.

The pharmacy manager said that the pharmacy had carried out patient satisfaction surveys prior to the relocation, 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. The pharmacy manager said that there had not been any recent complaints.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy and an external company. The pharmacy manager could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And 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 trained team members to provide its services safely. They do the right training for their roles and they are provided with some training to support their learning needs and maintain their knowledge and skills. They feel able to raise any concerns or make suggestions about the pharmacy or its services. And team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one locum pharmacist, one pharmacy technician (trainee accuracy checking technician), one trained dispenser (pharmacy manager) and one trainee dispenser working during the inspection. The trainee dispenser had only worked at the pharmacy for around one week. The inspector discussed the training requirements with the pharmacy technician. Most team members had completed an accredited course for their role and the trainee dispenser would be enrolled on an appropriate course when needed. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

The inspector discussed with the pharmacy manager about the reporting process in the event that a team member tested positive for the coronavirus. Team members were carrying out twice weekly lateral flow tests and reporting the results to the pharmacy manager.

The pharmacy manager appeared confident when speaking with people. He was aware of the restrictions on sales of pseudoephedrine containing products. And he would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. He used effective questioning techniques to establish whether the medicines were suitable for the person. And he provided guidance to people about how to take the medicines safely.

The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. He was an independent prescriber and worked at a GP surgery in this role, but he was not employed as a prescriber at the pharmacy. He explained that he attended training provided by the GP surgery and read pharmacy-related magazines to help keep his knowledge up to date. And he felt able to take professional decisions. The pharmacy manager said that team appraisals were due to be carried out, but had been delayed due to the relocation. Team members felt comfortable about discussing any issues with the pharmacist or superintendent. Information was passed on informally throughout the day. And targets were not set for team members.

The pharmacy manager said that team members were not provided with ongoing training on a regular basis, but they did receive some. Team members had access to online training provided by an external company and they could access the modules via an app. The pharmacy manager explained that team members did not currently have time during the day to undertake training due to ongoing work pressures during the pandemic and following the relocation. The pharmacy manager discussed any dispensing mistakes openly with the team.

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 without being heard.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout. Pharmacy-only medicines were kept behind the counter and a barrier was available to restrict access to this area. 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.

There had not been many adjustments made at the new premises with regards to Covid. People outside the pharmacy had a clear view of how many people were in the shop area, and they waited outside until the person in the pharmacy had left before entering. There were two chairs available in the shop area for people to use while waiting. These were not positioned away from each other at the start of the inspection. But these were moved during the inspection to help people maintain a suitable distance while in the seats. There was a sign asking people to maintain a two-metre distance from each other while in the pharmacy.

The consultation room was accessible to wheelchair users and it could be accessed from the shop area and the dispensary. There were windows in both doors and these were not covered so people in the shop and dispensary could clearly see into the room. There was a desk in the room and a reclining chair, but there were no chairs available for people to sit on while talking to a member of the team. The pharmacy manager said that the pharmacy was still in the process of completing the renovations and the points raised during the inspection would be addressed. 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. There were separate hand washing facilities available. There were two sinks in the dispensary and one was specifically for pharmaceutical use while the other was used for washing kitchen items.

Principle 4 - Services ✔ Standards met

Summary findings

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, so that people get medicines and medical devices that are safe to use. It dispenses medicines into multi-compartment compliance packs safely. But it 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 not currently advertised. The pharmacy technician explained that these would be displayed in the shop windows once all the renovations had been carried out. The pharmacy had two phone lines which helped when team members needed to make a call when someone was already on the phone. Lateral flow tests were provided to people where needed and the appropriate information was recorded.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But he did not make a record of blood test results. 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 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. The pharmacy manager said that he would ensure that prescriptions for higher-risk medicines and Schedule 3 and 4 CDs would he highlighted in the future. The pharmacist said he checked CDs and fridge items with people when handing them out. The pharmacy manager 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 did not the relevant patient information booklets available. The pharmacy manager said that he would order replacements from the manufacturer. The valproate warning cards were attached to the medicine packaging and were supplied each time the medicine was dispensed.

Stock was stored in an organised manner in the dispensary. The pharmacy manager said that expiry dates had been checked when the pharmacy relocated around one month ago. Some short-dated items were highlighted, but this was not consistently done. There were no date-expired items found with dispensing stock and medicines were kept in their original packaging. The pharmacy manager said that he would ensure that a more reliable date-checking system was implemented to help minimise the chance of out-of-date medicines being supplied to people.

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. Prescriptions were kept at the pharmacy until the remainder was dispensed. The pharmacy manager said that uncollected prescriptions were checked monthly and any items uncollected after around three months were

returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the person's medication record was updated to show that they had not collected the medicines. There were several bagged items waiting collection which did not have a copy of the prescription attached. The pharmacy manager said that he would ensure that these were left attached to the items until they were collected so that team members could easily check that the prescription was valid at the time of supply.

Prescriptions for 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. The pharmacy technician said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for 'when required' medicines were not routinely requested. The pharmacy manager said that 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 the pharmacy technician said that patient information leaflets were usually supplied every couple of months. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacy technician said that he would ensure that the leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs to help minimise the risk of contamination.

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 largely recorded. There were some entries which did not have a second signature recorded. The pharmacy technician said that he had witnessed the destruction and had forgotten to complete the paperwork.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The driver was asked to maintain a suitable distance from people while making deliveries and to check people's details before leaving the items with them. 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. 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, and separate liquid measures were used to measure certain liquids. Triangle tablet counters were available and clean. 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 phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures had been checked daily until 7 June 2021. Maximum and minimum temperatures had been recorded. And the records indicated that the temperatures were within the recommended range prior to this date. The current temperature was three degrees Celsius. But the maximum temperature had reached 8.5 degrees Celsius. The pharmacy manager said that he would ensure that the temperatures were checked daily in the future. 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.