General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Diabetes Consults, Unit 3, Centre Court, Sir Thomas Longley Road, Medway City Estate, Rochester, Kent, ME2 4BQ

Pharmacy reference: 9011717

Type of pharmacy: Community

Date of inspection: 11/12/2023

Pharmacy context

The pharmacy is in a small business park on an industrial estate. Its services are mainly offered on a face-to-face basis by appointment, but some can also be done remotely. The pharmacy provides bespoke private services offering a comprehensive review for people living with type 2 diabetes, hypertension, and cholesterol management. And it offers a phlebotomy service to help support people when they undertake a review for these conditions. The pharmacy also offers services under using patient group directions (PGDs) for weight management, travel vaccinations, urinary tract infections, women's health and men's health. The pharmacy has a contract with the Primary Care Network to offer COVID-19 vaccinations and health checks on a bus in the local area to help reduce health inequalities and help improve uptake of vaccinations. And the site also has registration with the Care Quality Commission (CQC).

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 identifies and manages the risks associated with its services. It has a process for recording any mistakes that happen during the dispensing process. The pharmacy protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. The pharmacy had undertaken risk assessments for some of the services including type 2 diabetes, hypertension, and cholesterol management. These had a clear guidance around the background of the disease, how to diagnose, clear inclusion and exclusion criteria, care planning, treatment, and ongoing monitoring required. The ongoing monitoring included reviews which were undertaken by a pharmacist, nurse, or endocrinologist. People had an option to choose who to have their review with.

At the time of the inspection, the pharmacy had only undertaken a small number of consultations as part of its private services, so it had not had the opportunity to carry out a clinical audit. The pharmacist independent prescriber (PIP) was also the superintendent pharmacist (SI) and described the plans the pharmacy had to undertake regular clinical audits and prescriber appraisals. The pharmacy had done an audit on whether key counselling advice would be given when prescribing a class of medication SGLT 2 (used to treat type 2 diabetes) in line with national alerts. The pharmacy had not prescribed this medicine yet but had reminded prescribers to give this advice at the time of prescribing.

The PIP said that there had not been any dispensing errors, where a dispensing mistake had reached a person. She said that if they occurred, they would be recorded on a designated form and a root cause analysis would be undertaken. The pharmacy had a near miss record available and this would be used to record dispensing mistake which were identified before the medicine had reached a person. The pharmacy had not dispensed many items prior to the inspection and there had not been any mistakes identified.

Team members' roles and responsibilities were specified in the SOPs. The PIP said that the pharmacy would open if the responsible pharmacist (RP) had not turned up. She said that people would be able to make enquiries and book appointments. And team members knew which tasks they should not undertake if there was no RP. There were no dispensed medicines available to check at the pharmacy. The PIP said that team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The PIP said that she had been prescribing and dispensing medicines without another person checking. She mentioned that there were plans to employ another qualified person to clinically check the prescriptions.

The pharmacy had current professional indemnity insurance for the services offered. The right RP notice was clearly displayed, and the RP record was completed correctly. A sample of patient records were checked during the inspection. All the necessary records were kept from the consultation and the treatment plan. Also, any discussions taking place between the person and the prescriber were

documented. The RP had full oversight of the consultation notes so they could make necessary interventions if needed. The private prescription records were completed correctly. There were signed in-date patient group directions available for the relevant services offered.

The pharmacy had a generic template for recording consultations. This included documenting a person's past medical history, social history, and any medicines they were taking. The PIP would, as part of the consultation process, check the person's medical history and blood test results to make sure it was safe and appropriate to prescribe any medicines. The PIP also documented any findings from physical examinations and observations such as blood pressure. And she documented any 'red flags' ruled out and safety-netting advice given. The pharmacy's phlebotomy service offered key blood tests for type 2 diabetes and hypertension such Hba1c and lipids. If people did not wish to have this done, the PIP wrote a letter of recommendation and signposted people to their regular prescriber to have this done before a prescription would be issued. The PIP documented what they prescribed and sent details about the medicines prescribed and indications for the treatment to the person's regular prescriber. And example was seen where the PIP had written directly to a consultant at a hospital in regard to treatment recommendations for a person's type 2 diabetes. And the pharmacy had received a positive response and the consultant had agreed with the recommendations. A sample of the weight loss consultation records were checked. And it was seen that the person's weight and BMI were recorded.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Team members had completed training about the protecting people's personal information. Information was shared electronically with people's usual prescriber.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. There had not been any recent complaints.

The pharmacist had completed level 3 safeguarding training and would only prescribe for people over 18 years of age. The PIP would undertake a video consultation to verify a person's identification if needed. But most of the consultations were face-to-face. The PIP 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. And they do the right training for the services they provide. There is support available for prescribers to help them work effectively and safely. Prescribers can exercise professional judgement and are available for queries relating to their prescribing. Team members are provided with ongoing training to support their learning needs. And they get time set aside in work to complete it. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There was the PIP and two trainee healthcare assistants working during the inspection. The PIP said that the two trainee healthcare assistants would be enrolled on an accredited dispenser course once they had completed their probationary period. And they would not be undertaking any dispensing tasks until then. Team members wore a name badges displaying their role.

At the time of the inspection, only the PIP had written prescriptions but there were plans to embed other clinicians from January 2024. Other clinicians included a diabetes nurse specialist, GP, and endocrinologist. The PIP was available during the day and in the event of absences, other prescribers would provide cover.

The PIP explained her previous experience where she worked with diabetic patients and had completed several courses in relation to diabetes. The prescribers were supported by a network of diabetic specialists for any learning needs, supervision, or support. The prescribers would receive feedback from the medical team and had support from them to clarify questions or receive advice on specific clinical cases. Although none had taken place at the time of the inspection, the pharmacy aimed to review prescribing quarterly with a yearly update and appraisal.

The PIP said that all medicines were dispensed and checked by her. And she took a break between dispensing and checking. She said that she was the only team member involved with supplying medicines to people. And this included selling general sales list or pharmacy-only medicines.

The trainee healthcare assistants had completed a phlebotomy course and their certificates were displayed in one of the consultation rooms. They had been undertaking some online training including, safeguarding, infection control, conflict resolution and basic life support. Training was monitored by the PIP and team members could complete the training during work.

The PIP was aware of the continuing professional development requirement for professional revalidation. She was able to make professional decisions to ensure that people using the pharmacy's services were safe. She had completed declarations of competence and consultation skills for the services offered, as well as associated training. Appropriate questions were asked as part of the consultation and the prescribers were encouraged to use their own professional judgement when prescribing. Examples were seen where orders had been rejected due to not having enough clinical information to safely prescribe. The PIP had oversight of the consultations and the pharmacy software identified when a prescription was last issued to help avoid unnecessary or excessive quantities being supplied. Documented examples were seen where prescriptions had been refused to help prevent the

oversupply of medicines to people.

The PIP explained that there were morning huddles at the pharmacy and on the bus. And team members would discuss any concerns raised ranging from clinical and non-clinical incidents. The PIP said that she would regularly liaise with the local vaccination team to share learning and discuss how to improve the services. Targets were not set for team members. The PIP said that team members underwent regular performance reviews during their probationary period.

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 which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Workspace in the dispensary was free from clutter. There were several chairs in the waiting area for people to use. And both consultation rooms were accessible to wheelchair users. The rooms were off the pharmacy’s waiting area, and they were well screened and suitably equipped. Conversations at a normal level of volume in the consultation room could not be heard from the waiting area.

The pharmacy’s website was clear and easy to use and provided details about the services available. And it included details about how people could contact the pharmacy if they had any queries about their appointment or treatment. It included the SI details, but it did not display the details of all prescribers the pharmacy used. Following the inspection, the PIP said that she would ensure that these details were included.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It manages its prescribing service well to ensure people get appropriate care and support to manage their conditions and medicines safely. And people can contact the pharmacy with any queries about their appointment or treatment. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. And it responds appropriately to drug alerts and product recalls. 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. Services and opening times were clearly advertised at the entrance to the pharmacy and on its website. The PIP said that if a person walked into the pharmacy, they would be offered an appointment and be asked to return if one was not immediately available. Identity checks were mostly carried out face-to-face and an ID was needed such as passport or driving licence. These checks were sometimes done via video call. The pharmacy did not provide services to people living outside of the UK. The pharmacy offered an interpreter service for people whose first language was not English.

Prior to the inspection the pharmacy had only done a small number of reviews, and these had been undertaken by the SI who was also a PIP. This mainly involved reviewing the diabetic medication and providing advice about how to optimise people's diabetes management. People booked an appointment via the pharmacy's website and the PIP would arrange a face-to-face or telephone call appointment. The PIP would take a detailed medical history from the person and where the person could not provide the medical history, the PIP would independently verify the medical history by requesting GP records or by accessing the persons NHS app. The pharmacy required people to give mandatory consent to share information with the GP and this was recorded. If they did not, then their consultation would not take place. Records were seen during the inspection where this had been done. On sampling the records, the PIP had documented the consultations on the pharmacy's computer system. Furthermore, there was evidence to show when medication had not been prescribed due to the PIP not having enough clinical information. And people had been signposted back to their GP to obtain relevant blood test markers before a prescription would be issued at 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. Stock was stored in an organised manner in the dispensary and medicines were kept in their original packaging. Expiry dates were checked regularly, and this activity was recorded. Stock due to expire within the next few months was marked. The pharmacy had an emergency bag which included an O2 cylinder, adrenaline, and a defibrillator. The medicines in the bag had not been date-checked since July 2023 and there was an expired medicine found in there. The pharmacist said that she would ensure that the emergency bag was included in the pharmacy's date-checking routine and that short-dated medicines would be replaces with medicines with a longer shelf life. Fridge temperatures were checked daily, and the 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.

There were no part-dispensed or uncollected prescriptions at the pharmacy. The PIP said that if an item was not in stock, it would be ordered and was usually available either the same day or the following day. The PIP said that the pharmacy kept one packet each of the common medicines it prescribed. The pharmacy had 'owings' notes available, and these would be provided if a prescription could not be dispensed in full.

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. Up-to-date reference sources were available in the pharmacy and online. The weighing scales and the shredder were in good working order.

The phones in the reception area and dispensary were portable so they could be taken to a more private area where needed. The pharmacy had emergency medicines, including an O2 cylinder, adrenaline, and a defibrillator. And it had anaphylaxis guidance available. The pharmacy had equipment for testing blood pressure and cholesterol and this was checked and calibrated in line with the manufacturer’s guidance.

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.