General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Joydens Wood Pharmacy, 2 Birchwood Parade, Woodside Drive, Wilmington Estate, DARTFORD, Kent, DA2 7NJ

Pharmacy reference: 1032690

Type of pharmacy: Community

Date of inspection: 08/03/2023

Pharmacy context

The pharmacy is on a parade of shops in a largely residential area. The pharmacy receives most of its prescriptions electronically. The pharmacy provides a range of services, including the New Medicine Service and it 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.

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 regularly seeks feedback from people who use the pharmacy. And team members know how to protect vulnerable people. The pharmacy records and reviews any mistakes that happen during the dispensing process to help make these processes safer. And it protects people's personal information well. It keeps the records it needs to and these are largely accurate and up to date.

Inspector's evidence

There were documented, up-to-date standard operating procedures (SOPs) available at the pharmacy. Team members explained that the pharmacist highlighted any near misses (dispensing mistakes that were identified before the medicine had reached a person) with them at the time of the incident. And once the mistake was highlighted, they were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser explained how the pharmacy would deal with any dispensing errors, where a dispensing mistake had reached a person. She said that the regular pharmacist kept a record, but she was not sure where this was. And she was not aware of any recent dispensing errors.

Workspace in the dispensary limited but it was largely free from clutter. And team members had clear space for dispensing and checking medicines. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And team members used baskets to help 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 said that pharmacy would open if the pharmacist had not turned up in the morning. She was not clear about which tasks should not be undertaken in the dispensary if there was no responsible pharmacist (RP) signed in. But she knew that she should not sell any pharmacy-only medicines or hand out dispensed medicines if the RP was not in the pharmacy. The inspector reminded team members what they could and shouldn't do if the pharmacist had not turned up.

The pharmacy had current professional indemnity and public liability insurance. Controlled drug (CD) registers examined were filled in correctly. 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 there were a few occasions recently where the locum pharmacists had not completed the record when they had finished their shift. Team members said that they would remind them to complete the record in future. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the prescriber's details were not routinely recorded. This could make it harder for the pharmacy to find these details if there was a future query.

People's personal information on bagged items waiting collection could not be read by people in the

shop area. 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 spine were stored securely and team members used their own smartcards during the inspection.

The pharmacy had carried out some recent patient satisfaction surveys and the results were displayed behind the medicines counter. The complaints procedure was available for team members to follow if needed. The dispenser explained that she would inform the pharmacist about any complaints, and he would deal with them. She said that there had not been any recent concerns about the pharmacy.

The pharmacist and dispenser had completed training about protecting vulnerable people. The dispenser knew the potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The dispenser said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. But it doesn't always ensure that they are enrolled on accredited pharmacy courses in a timely manner. Team members have access to some training to help support their learning needs and maintain their knowledge and skills. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. Team members can make suggestions about how to improve the pharmacy's services.

Inspector's evidence

There was one locum pharmacist, one trained dispenser and one person working on the medicines counter during the inspection. The person working on the counter had worked at the pharmacy for around ten months and had not been enrolled on an accredited course for her. The dispenser contacted the superintendent pharmacist during the inspection, and he said that he was in the process of enrolling her. Following the inspection and on the same day, the inspector received confirmation that they had been enrolled on an accredited course for their role.

Team members appeared confident when speaking with people. They were aware of the restrictions on sales of medicines containing pseudoephedrine. And they knew which medicines could be abused or may require additional care. They would refer to the pharmacist if a person asked regularly to purchase an over-the-counter-medicine. And they asked questions to establish whether a medicine was suitable for the person for the person it was intended for.

The dispenser said that the pharmacy manager provided team members with some training. And she had access to online training modules that she could complete in her own time. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. She had recently completed the online flu training. And she felt able to take professional decisions. Targets were set for the New Medicine Service. The dispenser said that the pharmacy usually met the targets and that the pharmacy provided the service for the benefit of people and not to meet the targets.

The dispenser said that team members had ongoing informal performance reviews. She felt able to discuss any issues with the pharmacist and could make suggestions. One of the team said that the pharmacy had briefly trialled a new way for storing bagged items. The new storage system would ensure that there were no items stored on the floor area as these sometimes posed as potential tripping hazards or the medicines were at risk of being damaged. But it had not been implemented.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. The premises provide a safe, secure, and clean environment for the pharmacy's services. But the pharmacy could do more to ensure that it is free from potential tripping hazards.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and generally tidy. Pharmacy-only medicines were kept behind the counter. 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 were several bagged items on the floor behind the medicines counter. Team members said that these being stored on the floor made it difficult for them to access bagged items on the shelves and they sometimes accidentally kicked the bags. There was a large pharmaceutical fridge in the shop area near to the consultation room. And it was accessible to people using the pharmacy and used to store medicines. The dispenser found the key for the fridge and locked it during the inspection. She said that it would be kept locked in future.

There were several chairs in the shop area. 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 in the shop area. 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. 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. And the pharmacy provides its services safely and manages them well. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. It dispenses medicines into multi-compartment compliance packs safely. And it gets its medicines from reputable suppliers and largely stores them properly.

Inspector's evidence

The pharmacy's services and opening times were clearly advertised and a variety of health information leaflets was available. 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.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Prescriptions for higher-risk medicines were highlighted with a 'see pharmacist' sticker. Team members knew to check with the pharmacist before handing these medicines out. The pharmacist said that she would check monitoring record books for people taking higher-risk medicines if such as methotrexate and warfarin. And she would record any results on the patient's medication record. The dispenser 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 (PPP). The pharmacist said that she would refer people to their GP if they were not on the PPP when they should be. The pharmacy had the relevant patient information leaflets, warning cards and warning labels for use with slit packs.

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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly and items due to expire before the end of the year clearly marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. 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 it was not overstocked. CDs were stored in a CD safe. 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.

The dispenser said that part-dispensed prescriptions were checked daily. And people were given an 'owing' note if their prescription could not be dispensed in full. They were kept informed about any 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 collected. Uncollected prescriptions were checked every couple of months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The dispenser said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. The dispenser said that 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. Prescriptions for 'when required' medicines were routinely requested, and the dispenser said that people contacted the pharmacy if they did not need them when their packs were due. She said that she would consider changing this process though to help minimise people receiving medicines they didn't need. 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.

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. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The driver had a cool box for transporting medicines that required refrigeration.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy largely has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

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. Suitable equipment for measuring liquids was available but the graduations were not suitable for pharmaceutical use. One of the team said that she estimated the volume if it was between graduations. She said that she would order suitable measures. 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.

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.