General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Pharmacy, 13-14 Cross Lane, FAVERSHAM, Kent, ME13 8PN

Pharmacy reference: 1032741

Type of pharmacy: Community

Date of inspection: 07/08/2019

Pharmacy context

The pharmacy is located near a busy high street in a town centre surrounded by residential premises. The people who use the pharmacy are mainly older people. The pharmacy receives around 95 per cent of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, flu vaccinations and blood pressure checks. It provides multi-compartment compliance packs to around 120 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

The pharmacy largely identifies and manages the risks associated with its services to help provide them safely. It largely protects people's personal information well. And it regularly seeks feedback from people who use the pharmacy. Team members understand their role in protecting vulnerable people. And the pharmacy generally keeps its records up to date.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. The pharmacy technician said that head office reviewed them for the whole organisation and informed the pharmacy about any common mistakes. Medicines in similar packaging or names were separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person returned the incorrect medicine to the pharmacy and they had not taken any of it. An incident report was completed and the correct medicine was supplied. The pharmacist said that the person was satisfied with how the incident had been dealt with.

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. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacy technician (accuracy checking technician (ACT)) was clear with which items she should not check. She knew that she should not check prescriptions which had not been clinically checked or if she had been involved in the dispensing process.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would not open if the pharmacist had not turned up. She confirmed that she would not carry out any dispensing tasks until the pharmacist had arrived. A pharmacy technician said that people would be referred to another local pharmacy if needed. She knew that dispensed items should not be handed out if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The prescriber's details were not recorded on the private prescription record. A pharmacy technician said that she would remind team members to record this when dispensing a private prescription. The nature of the emergency was not always recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that he would remind team members to record this. The pharmacist said that controlled drug (CD) running balances were checked at the time of dispensing and a full stock check was carried out regularly. The

recorded quantity of one item checked at random was the same as the physical amount of stock available. There were alterations made to the responsible pharmacist (RP) record. But there was no audit trail to show when these changes had been made or by whom. This could make it harder for the pharmacy to show who had made the alteration if there was a query. The correct RP notice was clearly displayed. And all necessary information was recorded when a supply of an unlicensed special was made.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Personal information on bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly satisfaction surveys; results from the 2017 to 2018 survey were available on the NHS website. Results were positive with over 96% of respondents rating the staff overall as ‘very good’. The pharmacy had received a recent complaint and this had been investigated. Head office had replied to the person in writing. The pharmacy complaints procedure was available for team members to follow if needed.

Team members had completed the Centre for Pharmacy Postgraduate Education 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 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 trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. 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. These are not affected by the pharmacy's targets.

Inspector's evidence

There were two pharmacists, one ACT, three pharmacy technicians and one dispenser working during the inspection. The pharmacy technician said that the MCA was on planned leave so other team members were covering the medicines counter. The team members wore smart uniforms with name badges displaying their role. They 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. She was aware of the restrictions on sales of pseudoephedrine containing products and knew the reason why. She confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

All team members had completed accredited training courses. A pharmacy technician said that team members were invited to attend evening training sessions provided by external agencies. She said that head office paid for travel and two hours additional pay and food was provided. The dispenser said that online training modules were available for team members to complete. And these were completed out of work time. The pharmacy technicians were aware of the requirement to complete Continued Professional Development for the professional revalidation process. The pharmacist said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. And the other pharmacist said that he was undertaking relevant training so that he could provide the services.

The pharmacy technician said that there were monthly staff meetings held to discuss any issues. The pharmacy received a monthly newsletter from head office and this included information about common mistakes throughout the organisation and updates to the SOPs. Team members read the newsletter and signed to indicate that they had understood the contents. The pharmacy technician said that she felt confident to discuss any issues with the pharmacy manager.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that the pharmacy met the targets and having two pharmacists helped. He did not feel under pressure to achieve the targets and felt that he would be supported by head office if the targets were not being met. He said that he carried out these services for the benefit of people using the pharmacy and he would not let the targets affect his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter. Barriers were used to restrict unauthorised access behind the medicines counter. There was a clear view of the medicines counter from the dispensary and the pharmacists 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 seven chairs in the shop area. Four were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. But three were directly in front of the counter. The pharmacist said that people were offered the use of one of the consultation rooms if they wanted to discuss something in private.

The pharmacy had two consultation rooms in the shop are and these were accessible to wheelchair users. They were suitably equipped and well-screened. Low level conversations in the consultation room could not be heard from the shop area. The rooms were not kept locked when not in use and there was some items inside which were not secured properly. The pharmacist said that he would ensure that these were secured in future.

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

The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. But the pharmacy 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 clearly advertised and variety of health information leaflets were available. There were several members of the team who actively managed the stop smoking service. The dispenser said that the pharmacy had around a 75% success rate with people stopping smoking. The pharmacy technician said that the pharmacy actively promoted the service and many pregnant people used it. The pharmacy carried out six health promotion campaigns each year. The most recent campaign was 'Be clear on cancer'. Posters were displayed and leaflets were available and promoted.

Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. A record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having relevant tests done at appropriate intervals. Prescriptions for Schedule 3 CDs were highlighted, but prescriptions for Schedule 4 CDs were not. The pharmacist said that he would highlight these to reduce the chance of these being handed out after the prescription had expired. The pharmacist said that the pharmacy supplied valproate medicines to a few people in the at-risk group. And there were a few people who needed to be on the Pregnancy Prevention Programme. Their medication record was annotated to show that the pharmacist had spoken with them about it. The pharmacy did not have the patient information leaflets or warning cards available. The pharmacist said that he would order some from the manufacturer.

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. But some items due to expire at the end of August 2019 had not been removed from dispensing stock.

The pharmacy technician said that part-dispensed prescriptions were checked twice a day. '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, but not until the items were collected. This could mean that there is a chance that medicines were handed out when the prescription was no longer valid. The pharmacist said that he would ensure that prescriptions were kept with dispensed items until they were collected. He said that uncollected prescriptions were checked monthly. Items uncollected after around three or four months were returned to dispensing stock where

possible. He explained that prescriptions for CDs were returned to the prescriber and others were returned to the NHS spine or disposed of appropriately in the pharmacy. And the person's medication record was updated.

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 not routinely requested; the dispenser said that the pharmacy routinely contacted people to see if they needed them. The pharmacy kept a record for each person which included any changes to their medication. They also kept 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. Patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. There were several team members who were responsible for managing the system.

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; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy generally obtained people's signatures for deliveries where possible. But there were several occasions recently where one of the delivery drivers had signed on behalf of the person and there was no record to show why the person was not able to sign. This could make it harder for the pharmacy to show that the medicines were safely delivered. The pharmacist said that he would check with the driver why there were so many records that the driver had signed. If 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 patient 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 head office. 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.

The pharmacy had the equipment installed for the EU Falsified Medicines Directive. The pharmacist said that the pharmacy had been using the equipment. But it had stopped recently due to being informed by a locum pharmacist that it was not needed yet. He said that he would ensure that the equipment was used in future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally 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 medicines was available but not for volumes less than five millilitres. The ACT said that she would order a suitable measure. Triangle tablet counters were available and clean. This helped avoid any cross-contamination. Methotrexate came in foil packs and there was no need for the loose tablets to be counted out in a triangle.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor was replaced regularly. The carbon monoxide testing machine was calibrated by an outside agency. 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; maximum and minimum temperatures were recorded. Records indicated that the temperatures were largely within the recommended range. If the temperature was outside the range an explanation was recorded. The fridges were suitable for storing medicines. The large fridge was full and there was little room for additional stock. The pharmacist said that an additional fridge had been requested but not yet received. He said that the pharmacy was not able to reduce the stock levels due to the volume of items dispensed and the variety of items needed to be stocked.

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.