General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Phoenix Pharmacy, 373 Maidstone Road, Wigmore, GILLINGHAM, Kent, ME8 0HX

Pharmacy reference: 1032773

Type of pharmacy: Community

Date of inspection: 31/07/2024

Pharmacy context

The pharmacy is on a small parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. And it supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. The pharmacy changed ownership in October 2023.

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 largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it protects people's personal information well. People can provide feedback about the pharmacy's services. 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. Team members' roles and responsibilities were specified in the SOPs. And team members said that the pharmacy would not open if the pharmacist had not turned up in the morning. They said that a notice would be displayed in the pharmacy window and the superintendent pharmacist (SI) would be informed. Team members knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the responsible pharmacist (RP) was not in the pharmacy.

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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Team members explained how improvements were made to help minimise the chance of a similar mistake and learning points were also shared with other pharmacies in the group. Enalapril and escitalopram were now stored separately to help minimise the chance of the wrong medicine being selected. Team members said that they were not aware of any dispensing mistakes that had reached a person (known as dispensing errors) since the pharmacy had changed owners. A dispenser showed how these would be recorded on the pharmacy's computer and she said that a route cause analysis would be undertaken by the pharmacist.

The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription.

The pharmacy had current professional indemnity insurance. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. 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 responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there were a few occasions recently where the pharmacist had not completed the record when they had finished their shift and a different pharmacist was working the following day. Team members said that they would remind the pharmacists to complete the record when they finished their shift in future. The private prescription records were mostly completed correctly, but the correct prescriber's details were not 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 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. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. Team members said that there had not been any recent complaints. And they would refer any complaints to the pharmacist and inform the superintendent pharmacist (SI).

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. And other team members had undertaken some safeguarding training. Team members could describe potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. Team members 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

Team members do the right training for their roles. And they are provided with some ongoing training to maintain their knowledge and skills. The pharmacy has enough team members to provide its services safely. Team members can raise any concerns. And they can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one locum pharmacist and three trained dispensers working on the day of the inspection. A team member explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The pharmacy was up to date with its dispensing and team members communicated effectively to ensure that tasks were prioritised.

Team members appeared confident when speaking with people. They were aware of the restrictions on sales of pseudoephedrine-containing products. And would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. They asked people relevant questions to establish whether the medicines were suitable for the person.

Team members said that they were not provided with ongoing training on a regular basis, but they did receive some. They said that the pharmacist passed on information to them during the day and provided them with pharmacy-related updates. And important information was shared using a group chat. The pharmacist was aware of the continuing professional development requirement for professional revalidation. She said that she had recently completed the Pharmacy First training. And she had completed declarations of competence and consultation skills for this service, as well as associated training. She said that she felt able to make professional decisions.

Team member explained that they had informal ongoing performance reviews, but these were not documented. They felt comfortable about discussing any issues with the pharmacist, pharmacy manager or SI. Targets were not set for team members. Team members said that the services were provided for the benefit of the people using the pharmacy.

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 against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. 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 was limited workspace in the dispensary. Work was underway in a room to the rear of the dispensary to create additional room for dispensing. There was seating in the shop area for people waiting for services. Team members explained that the consultation room was installed around five months ago. The room was accessible to wheelchair users and could be accessed from the dispensary and the shop area. It was suitably equipped, well-screened, and kept secure when not in use. And 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

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. It 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. 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 into 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 a variety of health information leaflets was available. Team members said that the pharmacy printed large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members said they checked CDs and fridge items with people when handing them out. 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 (PPP). And the pharmacy supplied these medicines in their original packaging. The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. Prescriptions for higher-risk medicines were not routinely highlighted. The pharmacist said that she only highlighted prescriptions if she needed to speak with the person about their medicines. She said that she did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And she did not routinely ask them about any blood test results. This could make it harder for the pharmacy to know that the person was having the relevant tests done at appropriate intervals.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. A team member 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. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Team members said that there had not been any CDs returned since the pharmacy changed owners. Team members said that returned CDs would be recorded in a register and destroyed with a witness, and two signatures would be recorded. And a returned CDs record was available to use. Fridge

temperatures were checked daily, and 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.

Part-dispensed prescriptions were checked frequently. '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 and collected. Uncollected prescriptions were checked regularly and items remaining uncollected after around three months were returned to dispensing stock where possible. Team members explained that prescriptions for these items were returned to the NHS electronic system or to the prescriber.

People had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. If a person had 'when required' medicines, these were not routinely requested. The dispenser said that the pharmacy would contact people to ask 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 it also kept any hospital discharge letters for future reference. There were no completed packs available on the day of the inspection. The dispenser explained how the packs were assembled and what information was on them. She said that 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 obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. 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.

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

Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. A team member said that she would order a suitable measure.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than one year. A team member said that it would be replaced in line with the manufacturer’s guidance. The weighing scales appeared to be in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.