

Registered pharmacy inspection report

Pharmacy Name: Fenns Chemist, 33-35 Parkwood Green, Rainham,
GILLINGHAM, Kent, ME8 9PW

Pharmacy reference: 1032774

Type of pharmacy: Community

Date of inspection: 21/11/2019

Pharmacy context

The pharmacy is located in a small shopping precinct in a largely residential area. It receives around 80% of its prescriptions electronically. And it provides a range of services, including Medicines Use Reviews and the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. And it 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. It provides substance misuse medications to a small number of people.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

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 records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its 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 by the pharmacy's head office. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Posters were displayed in the dispensary which highlighted some medicines which 'looked alike and sounded alike'. Dispensing incidents were reported to the pharmacy's head office and a root cause analysis was undertaken. The Regional Pharmacy Support Manager (RPSM) said that there had not been any recent dispensing incidents reported to the pharmacy. She explained that someone from head office would visit the pharmacy to investigate any incidents and learnings would be shared throughout the organisation.

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. A quad stamp was printed on prescriptions and dispensing tokens; the pharmacist initialled prescriptions which had been clinically checked and the accuracy checker initialled when she had carried out the accuracy check on these prescriptions. The accuracy checker knew which prescriptions she could check and confirmed that she would not check them 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 open if the pharmacist had not turned up. She knew that she should not hand out dispensed items or sell pharmacy-only medicines before the pharmacist was in the pharmacy. But she thought that she could carry out dispensing tasks. The MCA thought that she was allowed to sell General Sales List medicines if there was no responsible pharmacist signed in. The inspector reminded them what they could and couldn't do if the pharmacist had not turned up.

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. All necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date Patient Group Directions available for the relevant services offered. And the emergency supply record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. 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 private prescription records were mostly completed correctly, but the prescriber's details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. There were several private prescriptions that did not have the required information on them when the supply was made. The pharmacist said that she would ensure that prescriptions had all the required information on and that the private prescription record was completed correctly in the future. The responsible pharmacist (RP) log was largely completed correctly and the right RP notice was clearly displayed. There were alterations made to the 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 pharmacist said that she would ensure that these were altered properly in the future.

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. Bagged items waiting collection could be viewed by people using the pharmacy, but people's personal information was not visible. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were displayed in the shop, available in the pharmacy information leaflet and on the NHS website. Results showed that over 98% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The Regional Pharmacy Support Manager said that there had not been any recent complaints at the pharmacy.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had done some safeguarding training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser 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 was one pharmacist, one accuracy checker, three trained dispensers, one trainee dispenser and two trained MCAs working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. 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 pharmacy was in the process of undergoing a mock inspection on the day of the inspection. This was to help team members prepare for an inspection.

The MCAs appeared confident when speaking with people. They were aware of the restrictions on sales of pseudoephedrine containing products. And they explained that they 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.

Team members received regular ongoing online training and this was monitored by the regional team. There were regular training events organised by head office. Team members were encouraged to attend and were provided with additional pay, travel and a meal if they attended. They were sometimes allowed time during the working day during quieter periods to complete training. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. The pharmacist aware of the continuing professional development requirement for the professional revalidation process.

The pharmacy had been without a regular full-time pharmacist for around ten months. The pharmacist explained that she had worked at the pharmacy for around six weeks and she was in the process of implementing some changes to improve the systems. She felt able to take professional decisions.

Team members had yearly appraisals and performance reviews. They felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy received a monthly newsletter from the pharmacy's head office, and this included important information and information about similar medicines. The pharmacy had regular meetings to discuss any issues or changes. The pharmacist had recently implemented a new rota so that each team member had a specific task for their shift, but they would also help each other out when needed.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that she carried out the services for the benefit of the people who used the pharmacy and she would not let the targets affect her professional judgement. She felt fully supported by the pharmacy's head office and additional cover was provided when needed. She mentioned that there were plans for a permanent

second pharmacist to be work at the pharmacy on a regular basis.

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; this presented a professional image. Pharmacy-only medicines were kept behind the counter and a barrier was used to restrict unauthorised access. 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; the room temperature was suitable for storing medicines.

There were three chairs in the shop area for people to use. These were positioned away from the main medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Low-level conversations 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. The pharmacy gets its medicines from reputable suppliers and stores them properly. 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 a variety of health information leaflets was available. The dispenser explained how the pharmacy had made adjustments for some people who used the pharmacy.

The pharmacist said that she sometimes checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. 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 highlighted. This helped to 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. The dispenser said they checked fridge items with people when handing them out. 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. Most of the medicine boxes for valproate had the warning cards attached. But the pharmacy did not have the relevant patient information leaflets or additional stickers available. The pharmacist said that she would order replacements 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 few months were marked. There were several date-expired items found in with dispensing stock. The pharmacist explained that the pharmacy was in the process of carrying out date checking and she would implement a more reliable system in the future.

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 monthly and items uncollected after around three months were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or disposed of appropriately in the pharmacy. The dispenser said that the pharmacy attempted to contact people after three months to remind them about their uncollected medicines.

The pharmacy was in the process of carrying out assessments for people who had their medicines in multi-compartment compliance packs to show that these were needed. 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 usually contacted people to see if they needed them when their packs were due.

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 obtained people's signatures for deliveries where possible and these were recorded in a way so that other people'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.

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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. Team members had undertaken training on how the system worked and there were written procedures available.

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. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced yearly. 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 consistently within the recommended range. 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.