General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Nicholson & Keep, 1 The Parade, Valley Drive, GRAVESEND, Kent, DA12 5RT

Pharmacy reference: 1032802

Type of pharmacy: Community

Date of inspection: 12/02/2024

Pharmacy context

The pharmacy is a on a parade of shops in a largely residential area and it is a family-run business. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First Service, flu vaccinations and a hypertension case-finding service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people.

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 to help provide them safely. People using the pharmacy can provide feedback about its services. And team members understand their role in protecting vulnerable people. The pharmacy protects people's personal information well. And it largely keeps its records up to date and accurate.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) and 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. Team members knew that they should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. And they knew what they could not do if the pharmacist had not turned up in the morning. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The superintendent pharmacist (SI) said that there had not been any recent complaints.

Team members explained that near misses (where a dispensing mistake 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. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were not recorded which could make it harder for the pharmacy to identify patterns. The pharmacist said that he would encourage team members to record their own mistakes on the near miss record and he would review them regularly for patterns. The pharmacist said that he was not aware of any recent dispensing errors (a dispensing mistake had happened, and the medicine had been supplied to a person). He explained that he would make a record of any error and undertake a root cause analysis.

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 initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The private prescription record and emergency supply record were completed correctly. Controlled drug (CD) registers examined were filled in correctly. CD running balances were checked at regular intervals and any 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 right responsible pharmacist (RP) notice was clearly displayed, and the RP record was largely completed correctly. But there was an occasion recently where the RP had not completed the record when they finished their shift, and a different pharmacist was RP the following day. The pharmacist said that he would ensure that the pharmacists working at the pharmacy were reminded to complete the RP record correctly in future.

Confidential waste was either shredded in the pharmacy or it was removed by a specialist waste contractor. 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 not be viewed by people using the pharmacy.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had also completed some safeguarding training. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to one of the pharmacists. One of the dispensers said that there had not been any recent safeguarding concerns at the pharmacy. But she gave an example of action she had taken in response to a safeguarding concern a couple of years ago. 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. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can take professional decisions to ensure people taking medicines are safe. And they can raise concerns to do with the pharmacy or other issues affecting people's safety.

Inspector's evidence

There were two pharmacists (one was also the SI), one trainee pharmacy technician and two trained dispensers working during the inspection. Team members explained that they undertook different roles each day and this was to ensure that they could provide cover where needed. Team members communicated effectively during the inspection, and they worked well together to ensure that tasks were prioritised. The pharmacy was up to date with its dispensing and the workload was well managed.

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

The pharmacists were aware of the continuing professional development requirement for professional revalidation. And they felt able to make professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And had undertaken the required training for the Pharmacy First Service. One of the dispensers said that team members were not provided with ongoing training on a regular basis, but they did receive some. She explained that she had recently completed training for the Pharmacy Quality Scheme. And training could be completed at the pharmacy when it was quieter, or it could be accessed at home.

Team members said that there were informal huddles in the morning to ensure that tasks were allocated, and any issues could be discussed. And she said that team members had their performance reviewed informally on an ongoing basis. Team members appeared to have a good working relationship with the pharmacist and SI, and they felt comfortable about discussing any issues with them. Targets were not set for team members. The SI said that the New Medicine Service was 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 from unauthorised access and pharmacy-only medicines were kept behind the counter. It was bright, clean, and tidy throughout which presented a professional image. 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. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

There was one chair in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened and conversations at a normal level of volume in the consultation room could not be heard from the shop area. There were lockable cabinets in the consultation room to store medicines and other items, but the key had been left in one of the cabinets. The pharmacist said that he would ensure that the sharps bin was removed from the consultation room and he would remind team members to lock the cabinets in future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and generally 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. People pressed a button to open the sliding door to enter the pharmacy and the door opened automatically when people wanted to leave. 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 pharmacy could produce large-print labels for people who needed them.

Bag labels for Schedule, 2, 3 and 4 CDs had the expiry date of the prescription printed on them. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. The pharmacist said that the pharmacy supplied valproate medicines to a few people. The pharmacy had recently undertaken an audit and the pharmacy did not currently supply valproate medicines to anyone in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist explained that the pharmacy was supplying valproate medicines in original packs. And people would be referred to their GP if they needed to be on the PPP and weren't. The pharmacist said that he would highlight a prescription for a higher-risk medicine if he needed to speak with the person. But prescriptions for these medicines were not routinely highlighted. So, opportunities to speak with some people when they collected their medicines might be missed. The pharmacy did not keep a record of people's blood test results. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that he would record blood test results on the patient's medication record in future. There were signed in-date patient group directions for the relevant services.

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 and the pharmacy kept a record of any action taken for future reference. Stock was stored in an organised manner in the dispensary. One of the dispensers said that expiry dates were checked regularly but this activity was not recorded and items with a short shelf life were not highlighted. There were a couple of expired medicine found with dispensing stock during a spot check and one had expired in December 2022. Medicines were largely kept in their original packaging but there was a medicine found during the spot check that was not kept in its original packaging. And the pack did not include all the required information on the container such as batch number or expiry date. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The SI said that the pharmacy would implement a more reliable date checking system and he reminded team members to dispose of any medicines not in their original packaging.

Fridge temperatures were checked daily, and maximum and minimum temperatures were routinely 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 kept secure and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept separate from dispensing stock. But the pharmacy did not keep a record of CDs that people had returned. The pharmacist said that he would consider doing this so that there was an audit trail to show what CDs were in the cabinet.

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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked regularly. Uncollected items were returned to stock where possible if they had not been collected after around three months. And prescriptions for these items were returned to the NHS electronic system or to the prescriber.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. The pharmacy requested prescriptions for the packs in advance so that any issues could be addressed before people needed their medicines. Prescriptions for ‘when required’ medicines were not routinely requested. The dispensers said that the pharmacy contacted people to ask if they needed these medicines 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. Packs were largely labelled correctly, but the additional warning and cautionary advisory labels were not on the backing sheets. One of the dispensers said that she knew how to amend this and would show other team members. Medication descriptions were put on the packs to help people and their carers identify the medicines, but patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that these were supplied in future. Team members wore gloves when handling medicines that were placed in these packs. The packs were assembled in an area towards the rear of the dispensary to help minimise distractions.

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. 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

Suitable equipment for measuring liquids was available. Separate liquid measures were used to measure certain medicines only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which 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.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The weighing scales and the shredder were in good working order. And the pharmacist said that the blood pressure monitor was replaced yearly.

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.