General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, 126 - 128 Ashford Road, Bearsted, MAIDSTONE, Kent, ME14 4LX

Pharmacy reference: 1032821

Type of pharmacy: Community

Date of inspection: 07/02/2023

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. And it is co-located with a Post Office. The pharmacy provides a range of services, including the New Medicine Service, flu vaccines, blood pressure checks and stop smoking service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large people who live in their own homes to help them manage their medicines. And it receives most of its prescriptions electronically.

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	1.2	Good practice	The pharmacy monitors its services and regularly reviews them to ensure that they are provided safely.
2. Staff	Standards met	2.2	Good practice	The pharmacy promotes learning, continuous improvement and the personal development of its team members. They get regular ongoing training and get time set aside at work to complete it.
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. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. The pharmacy keeps its records largely up to date and accurate. And it protects people's personal information well. People using the pharmacy can provide feedback about its services. And the pharmacy can protect vulnerable people where needed.

Inspector's evidence

The pharmacy held electronic versions of its standard operating procedures (SOPs). Team members had access to these, and the pharmacy's head office ensured that they had read, understood, and agreed to follow them. The accuracy checking technician (ACT) explained that she would inform a team member if they had made a near miss error (where a dispensing mistake was identified before the medicine had reached a person). And she would allow them time to identify the mistake themselves. They were then responsible for rectifying their mistake and this would then be re-checked by the ACT or pharmacist. Near misses were recorded on the pharmacy's computer system and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The outcomes from the near miss reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. The different strengths of pregabalin had been recently rearranged following a review of the near misses where the wrong strengths had been selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The ACT said that she was not aware of any recent dispensing errors.

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 pharmacist initialled prescriptions he had clinically checked so that the ACT knew she could carry out the accuracy check. She knew which medicines she could check and knew that she must not have been involved in the dispensing process for them.

Team members' roles and responsibilities were specified in the SOPs. Team members explained the process they would follow if the pharmacist had not turned up in the morning. They would contact the pharmacy's head office and inform people that they could not hand out any dispensed medicines or sell any medicines. And they knew that they should not hand out any dispensed medicines or sell any pharmacy-only medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the prescriber's full details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. There were signed in-date patient group directions available for the relevant services offered. 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 completed correctly.

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 electronic services were stored securely and team members used their own smartcards during the inspection. People's information on bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about protecting people's information.

The pharmacy's complaints procedure was available for team members to follow if needed and details about it were displayed next to the medicines counter. One of the team said that they would refer any concerns to the pharmacist. The pharmacist said that there had not been any recent complaints, but he would refer them to the pharmacy's head office if needed. He said that people could complain via the pharmacy's website and the pharmacy's head office would inform the pharmacy about it.

Team members had completed training about protecting vulnerable people. Team members described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. The team 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. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, one ACT, five trained dispensers (two were training to be accuracy checkers and one was on the NVQ level 3 pharmacy course), one trainee dispenser and one trained medicines counter assistant (MCA) 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 throughout the inspection to ensure that tasks were prioritised, and the workload was well managed. And they helped cover the medicines counter to ensure that the queue was kept to a minimum.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She explained that team members discussed occasions where people had been asking to purchase these medicines frequently. She asked people relevant questions to make sure that the medicine was suitable for the person they were buying it for.

The dispenser enrolled on the NVQ level 3 pharmacy course said that she was given protected training time each week. The pharmacist explained that various training modules were available online for all team members and these could be accessed at home or in the pharmacy using a portable electronic tablet. Team members were allowed time during the working day to complete the training and the pharmacist ensured that the mandatory training was completed. There were electronic and paper copies of training certificates for team members. The pharmacist said that the pharmacy's head office also monitored the training. The pharmacist and ACT aware of the continuing professional development (CPD) requirement for the professional revalidation process. The pharmacist said that he had recently undertaken the face-to-face flu training. He completed monthly CPD and kept a record of these. He felt able to take professional decisions. He said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The team said that they had regular informal huddles to discuss any issues and allocate tasks. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. Team members had yearly appraisals and performance reviews. There were also ongoing informal ones throughout the year. One of the team had been newly appointed as the administration manager for the pharmacy and one of her tasks would be to undertake the appraisals. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they could contact the pharmacy's HR department if needed. Targets were not set for team members.

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. 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. Kitchen and toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

There were a few chairs in the shop area for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The pharmacy's consultations rooms were accessible to wheelchair users and were in the shop area. They were suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. And it gets its medicines from reputable suppliers and stores them properly. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And it dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The main entrance could be opened with a push button mechanism and the button was clearly signposted. Services and opening times were clearly advertised and a variety of health information leaflets was available. There was an induction hearing loop available at the Post Office counter if needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin when these were available. And prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were clearly highlighted and the date the items were not to be handed out after was recorded on the prescription. Dispensed fridge items were kept in clear plastic bags to aid identification. Team members said that they checked CDs and fridge items with people when handing them out. The pharmacist said that all patients taking valproate medicines were provided with warning cards relevant patient information leaflets. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacist said that if someone need to be on one and wasn't, then he would refer them to their GP.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. One of the dispensers 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. Team members said that items due to expire within the next three months were marked. And there were no date-expired items found in with dispensing stock. The fridges were suitable for storing medicines and were not overstocked. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. The pharmacist said that CDs that people had returned, and expired CDs were clearly marked and segregated. But there were none in the cabinet on the day of the inspection as these had recently been destroyed. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

A team member explained that the part-dispensed prescriptions were checked daily. ‘Owings’ notes were provided when prescriptions could not be dispensed in full, and people were kept informed about 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 regularly. One of the team explained the process and said that prescriptions remaining uncollected after around two months were returned to the NHS electronic system or to the prescriber. And items were returned to dispensing stock where possible.

People had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. One of the dispensers explained the pharmacy’s processes for managing the prescriptions and packs. Some prescriptions were sent to the pharmacy’s dispensing hub to be dispensed. And others were dispensed in the pharmacy. The pharmacy requested prescriptions for the packs in advance so that any issues could be addressed before people needed their medicines. And people generally informed the pharmacy when they were running low on their ‘when required’ medicines so that prescriptions for these could be requested. 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. And the packs dispensed by the hub had photos of the medicines on to further aid identification.

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 and 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.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced yearly by the pharmacy’s head office. The carbon monoxide testing machine was calibrated by an outside agency and the weighing scales were 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.