General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, 12 & 16 Martin Square, Larkfield, MAIDSTONE, Kent, ME20 6QJ

Pharmacy reference: 1032838

Type of pharmacy: Community

Date of inspection: 22/05/2019

Pharmacy context

The pharmacy is in a small shopping precinct in a residential area a few miles from Maidstone. It serves a mix of people, including a 100 unit assisted living housing complex for the over 50s, one 48 bed care home and one ten bed hospice. The pharmacy provides a range of services, including; Medicine Use Reviews and the New Medicine Service. It supplies medicines in multi-compartment compliance packs to around 220 people who live in their own homes to help them take their medicines safely. And provides substance misuse medicines to around six people.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.2	Standard not met	The pharmacy does not keep all prescription only medicines securely. And it does not always protect people's personal information properly. This could mean that unauthorised people could potentially access these.
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 generally identifies and manages the risks associated with its services. The pharmacy mostly protects people's personal information. It actively seeks feedback from the public. And team members understand their role in protecting vulnerable people. The pharmacy keeps the records required by law, but they are not always complete. So, they may be less reliable in the event of a future query.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, regularly reviewed standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. The SOPs did not always reflect current practices in the pharmacy. Baskets were not being used during the dispensing process to help minimise the risk of medicines being transferred to a different prescription. And medicines were not always checked against a prescription before being placed into a multi-compartment compliance pack. There were occasions when packs were assembled without a valid prescription at the pharmacy. This could increase the chance that a mistake could be made. The pharmacy technician said that she would speak with the pharmacy manager about possibly amending the SOPs to reflect the practice they had of not using baskets.

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 trends and patterns. Medicines in similar packaging or with similar names were separated where possible. Shelves were highlighted with the names of medicines which were similar. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where two people's medicines had been bagged together and delivered to someone. The report did not contain much detail about the incident. Prescribing errors were recorded so that these could be referred to if needed.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. The dispenser accuracy checker said that the pharmacy had tried to use baskets during the dispensing process. But team members preferred not to use the baskets. The medicines were stacked neatly on prescriptions and there was a gap between these. 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. The pharmacy technician (accuracy checking technician (ACT)) was clear on which prescriptions she could accuracy check. She knew that she should not check items if she had been involved in the dispensing of these.

Team members roles and responsibilities were specified in the SOPs. The medicines counter assistant (MCA) said that the pharmacy would open if the pharmacist had not turned up. She thought that she could sell general-sales-list medicines before the pharmacist had arrived. She knew that she should not sell pharmacy-only medicines or hand out bagged items if the pharmacy was not on the premises. Some team members were not aware that dispensing tasks should not be carried out when there is no responsible pharmacist. 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 in place. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. The records of supply of unlicensed medicines could not be found. The pharmacy technician confirmed that all necessary information was recorded when a supply of these medicines was made. The prescriber details were not routinely recorded on the private prescription record. The nature of the emergency was not routinely 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 a medicine was supplied if there was a query. Signed in date patient group directions were available for the services offered. Controlled drug (CD) running balances were checked around once month; liquid overage was recorded in the register. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The address of the supplier was not routinely recorded in the CD register. The responsible pharmacist (RP) record was completed correctly and the correct RP notice was clearly displayed.

Confidential waste was shredded and the people using the pharmacy could not see information on the computer screens. Computers were password protected. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. There was some people's personal information visible to people using the pharmacy (see Principle three). Several bag labels and other personal information was in with general waste in the bin next to the medicines counter. The MCA removed these for destruction. She knew that it should not have happened and said that they routinely shredded them. Team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2017 – 2018 survey were displayed in the shop area and were available on the NHS website. These showed that over 90% of respondents were satisfied with the pharmacy overall. The pharmacist said that he was not aware of any recent complaints. The complaints procedure was available for team members to follow when needed. It was also displayed in the shop area.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Team members had completed online safeguarding training provided by the pharmacy. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that he was not aware of any safeguarding incidents at the pharmacy since he started around two years ago.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with some ongoing training to support their learning needs and help 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 regular pharmacist, one pre-registration pharmacy student, two pharmacy technicians (ACT), five dispensers (one NVQ level 3 qualified), three MCAs (one NVQ level 2 qualified) and one trainee MCA. The team 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 MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. She 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. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

Team members had either completed an accredited training course or were enrolled on one. The pharmacy technician said that registrants completed training modules provided by the CPPE. The pharmacy provided regular training events in the evening. Team members were provided with additional pay to encourage them to attend. The pharmacy received a newsletter from head office. The pharmacy technician said that team members had access to the newsletter, but they were not given specific time set aside during the day to read this. The team seemed unaware of any online training modules that may be available to them. The pre-registration pharmacy student said that he was allowed time during the day to complete training. He said that the pharmacy manager was his tutor. The pharmacy provided training days away from the pharmacy. The pharmacist said that he had completed consultation skills training and declarations of competence for the services offered.

Team members received performance reviews and appraisals. The pharmacy technician said that most of the team had theirs in Decembers 2018. But there were a couple of the team still due to have them. The pharmacy technician said that there was generally more than twelve months between reviews. She said that there were pharmacy meetings held around once a month to discuss any issues. And confirmed that she felt confident to discuss any issues with the pharmacy manager. She said that he was open to suggestions for change to improve services or routines. She described how a member of the team had highlighted an issue with some multi-compartment compliance packs waiting for prescriptions. She said that due to the change of schedule for pregabalin and gabapentin there were many more packs waiting for prescriptions for these medicines. These were now kept in a separate area and a pharmacist checked the contents against the backing sheet. When the prescription was received, this was checked against the backing sheet before the pack was supplied.

Targets were set for Medicine Use Reviews (MUR) and New Medicine Service (NMS). The pharmacist said that he carried out these services for the benefit of the patients and not to meet targets. He said

that the pharmacy regularly met the targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But the pharmacy doesn't always keep dispensed medicines securely or protect people's personal information on them properly.

Inspector's evidence

The pharmacy was secured from unauthorised access. Pharmacy-only medicines were kept behind the counter. It was bright, clean and tidy throughout; this presented a professional image. Air-conditioning was available; the room temperature was suitable for storing medicines.

There were eight chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The shop area was large and there were three tills at the counter.

The consultation rooms were accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area. Blinds were used to cover the windows. ‘Engaged/vacant’ signs were available on the doors. The rooms were kept locked when not in use. The rooms were suitable for the services offered. And they were accessible to wheelchair users.

Some bags of dispensed medicines were not kept securely. And some people's personal details were potentially visible on them. 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

People with a range of needs can access the pharmacy's services. The pharmacy generally provides its services safely. It gets its medicines from reputable suppliers and it generally manages them well. But it doesn't always remove expired medicines from stock promptly. This could increase the chance that people receive a medicine which is past its 'use-by date'. The pharmacy responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. The pharmacy team had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of patient information leaflets were available. Services and opening times were clearly advertised.

There were several team members able to carry out blood tests for people taking warfarin. Results were recorded on the patient's medical record and in the person's monitoring record book. The dispenser said that she carried out the test and recorded the results in the book. A summary sheet was printed and sent to the surgery. She had received training to provide the service. She said that the pharmacist checked all the results.

The pharmacist said that he checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. But a record of results was not kept, except for those people who used the warfarin testing service. This could make it harder for the pharmacy to monitor people's previous blood test results. Prescriptions for these medicines were not highlighted so there was potential that the opportunity to speak with these people was missed. Prescriptions for schedule 3 CDs were clearly highlighted. The pharmacist said that prescriptions for schedule 4 CDs were not generally highlighted. The MCA was unsure how long these prescriptions were valid for. This could make it more likely that these medicines may be handed out after the prescription had expired.

Prescriptions for schedule 2 CDs or medicines requiring refrigeration were dispensed when the person presented to collect their medicines. The pharmacist said they checked CDs and fridge items with people when handing them out. He confirmed that people taking valproate medicines had been provided with warning cards and patient information leaflets where needed. He said that the pharmacy supplied valproate medicines to a few female patients. But it did not have warning cards available. The pharmacy technician said that the additional stickers had been ordered and she would check whether the warning cards were on order.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked around every three months and this activity was recorded. Stock due to expire within the next six months was marked. But there were several expired medicines found with dispensing stock. Some areas had not been date checked for over four months. Medicines were generally kept in appropriately labelled containers. There was a dispensing pot with a medicine in which had no indication of how long the medicine had been in there and there was no indication that the medicine had been checked to ensure that it was labelled with the correct details. This could increase the chance of expired medicines being supplied. And may mean that it cannot take appropriate action when there is a medicine recall or alert.

The dispenser said that part-dispensed prescriptions were checked frequently. 'Owings' notes were provided, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were marked with any action taken, so that other team members were aware. Prescriptions were generally kept with dispensed medicines until the medicines were collected. There were several bagged items waiting collection that did not have prescriptions attached. This could make it harder for the team members to refer to the prescriptions if they needed to. The dispenser said that uncollected prescriptions were checked monthly. Items uncollected after around three months were returned to dispensing stock. The dispenser confirmed that she informed the surgery when prescriptions had not been collected and these were then shredded. She returned others to the NHS spine so that these could be re-dispensed if needed. And the patient's medication record was updated.

Prescriptions for people receiving their medicines in compliance packs were ordered in advance so that any issues could be addressed before they 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. Several team members were involved with the process and could provide cover where needed. The pharmacy kept a record for each patient 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 tray. Patient information leaflets were routinely supplied. The pharmacy technician said that team members generally used tweezers to handle medicines when placing them into the trays.

The pharmacy technician said that the pharmacist visited the hospice twice a week to carry out clinical checks on the drug charts and was in the process of writing some SOPs for the hospice team members. One of the pharmacy technicians visited the hospice weekly to ensure that they had enough stock. CDs were ordered on requisition forms from the pharmacy. The pharmacy manager said that the pharmacy had a wholesale dealer's licence and a Home Office licence to cover this activity. Any additional medicines not stocked at the hospice was supplied against the drug charts.

The care home was responsible for ordering prescriptions for their residents. The pharmacy was provided with a list of medicines ordered. And these were cross referenced with the prescriptions received from the surgery. The pharmacy technician said that a doctor visited the care home once a week. She said that a member of the care home team contacted the pharmacy to inform them about any additional medicines and these were generally sent the same day. Packs were assembled in a room adjacent to the dispensary to help minimise distractions.

CDs were kept securely. Denaturing kits were available for the safe destruction of CDs. CDs people had returned, and expired CDs were generally marked and segregated. The date of opening was not recorded on opened bottles of methadone. There were two bottles which had been opened longer than one month ago and these were not segregated in the cabinet. This could make it harder for staff to now if these were still safe to use. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by delivery drivers (between 40 – 80 deliveries a day). The pharmacy obtained people's signatures for deliveries where possible; these were recorded in a way so that another person's information was protected. A list of items taken for delivery was left at the pharmacy, so people could be informed that their medicine was due to be delivered that day if they contacted the pharmacy. The driver was seen informing a member of the team about a failed delivery. The dispenser said that she would attempt to contact the person or contact the surgery to ask if they were in hospital.

Only licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and

recalls were received from head office. These were actioned, and any action taken was recorded and kept for future reference. Team members had received training and the equipment was in place in preparation for the implementation of the EU Falsified Medicines Directive. But the pharmacy technician said that it was not yet being used.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available. Separate measures were marked for methadone use only. Triangle tablet counters were available and clean; a separate counter was marked for methotrexate use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to handle the medicines.

The blood pressure monitor was due to be replaced. The carbon monoxide meter was calibrated by an outside agency. The phone in the dispensary was portable so could be taken to a more private area where needed. The shredder was in good working order. Fridge temperatures were checked daily; maximum/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.