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: 06/02/2020

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, influenza vaccinations, INR tests, Pharmacy First minor ailments scheme, smoking cessation (Champix and nicotine replacement therapy). It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes to help them take their medicines safely. And provides substance misuse medicines to a small number of people and a needle exchange service.

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 protects people's personal information well and people can feedback about the pharmacy's services. Team members can protect vulnerable people. And they record and review mistakes so they can learn and make the services safer. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. The pharmacy has written procedures to explain its processes. But the procedures do not always reflect how the pharmacy works in practice. So, team members may not always be fully clear on how the processes are meant to be carried out.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with pharmacy activities. These included; documented standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. The SOPs did not always reflect current practices in the pharmacy. The SOPs specified that baskets should be used during the dispensing process to help minimise the risk of medicines being transferred to a different prescription. But they were not always being used in practice. The dispenser said that she had emailed the clinical governance lead about possibly amending the SOPs to reflect the practice they had of not using baskets. 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, but not supplied, without a valid prescription at the pharmacy. The dispenser explained that four weeks-worth of packs were assembled using the first week's prescription and three of the packs were quarantined until the remaining prescriptions were received. These packs were kept on separate shelves and were clearly marked that they were not to be given out until checked. The prescriptions, when received, were checked against the contents which had been previously checked by a pharmacist, but the original packaging for the medicines was not available during the final check. This could make it harder for the pharmacist to check the medicines in the packs. Team members had clearly marked that these compliance packs were not to be handed out until the prescriptions had been received and the packs had been checked by a pharmacist.

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. The outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Medicines in similar packaging or with similar names were separated where possible. And some shelves were highlighted with the names of medicines which were similar to another to help minimise the chance of the wrong medicine being selected. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong needles had been supplied to a person. This had been reported to the pharmacy's head office and the person was supplied with the correct needles.

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 not used to separate medicines and prescriptions during the dispensing and checking processes. The medicines were stacked neatly on prescriptions and there was a gap between these. There were designated checking areas and the

checkers ensured that they checked one person's prescriptions in these areas at a time. This helped to minimise the chance of medicines being mixed up. Team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacists initialled prescriptions that they had clinically checked. The 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 dispenser said that the pharmacy would open if the pharmacist had not turned up and the pharmacy's head office would be informed. The trainee medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines if the pharmacist was not in the pharmacy, but she thought that she could hand out dispensed items which had been checked by the pharmacist. The inspector reminded her what she could and couldn't do if the pharmacist was not in the pharmacy. The ACT knew that team members should not sell any medicines, hand out dispensed items to people or to the delivery driver before the pharmacist had turned up. Team members knew that they should not carry out any dispensing when there was no responsible pharmacist.

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. The responsible pharmacist (RP) record was completed correctly and the right RP notice was clearly displayed. And signed in date patient group directions were available for the services offered. Controlled drug (CD) running balances were checked at regular intervals and 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. All necessary information was recorded when a supply of an unlicensed medicine was made. The prescriber details were not routinely recorded on the private prescription record. This could make it harder for the pharmacy to find these details if there was a future query. 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.

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. Team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from a recent survey were displayed in the shop area and results from the 2018 to 2019 survey were available on the NHS website. Results were positive and over 95% of respondents were satisfied with the staff overall. The ACT said that she 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 pharmacists and ACT had completed the Centre for Pharmacy Postgraduate Education (CPPE) training about protecting vulnerable people. Other team members had completed online safeguarding training provided by the pharmacy. The MCA 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 ACT said that she was not aware of any safeguarding incidents at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They generally do the right training for their roles. And they are provided with ongoing training to support their learning needs and maintain their knowledge and skills. Team members are comfortable about raising concerns to do with the pharmacy or other issues affecting people's safety and they 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. But the pharmacy could do more to ensure that team members are enrolled on accredited pharmacy courses in a timely manner.

Inspector's evidence

There were two pharmacists, one pre-registration trainee, one ACT, five trained dispensers, one trainee dispenser, one trained MCA and two trainee MCAs working during the inspection. Most team members had completed an accredited course for their role and the rest were undertaking training. But one of the trainee MCAs said that she had worked at the pharmacy since around May 2019 and had not been enrolled on an accredited course for her role. She said that she was due to finish working at the pharmacy at the end of the month. The ACT said that she would speak with the pharmacy manager to ensure that team members were enrolled on accredited courses within the required timeframe in the future. Following the inspection, the superintendent pharmacist confirmed that all team members had either completed an accredited course, or had been enrolled on one. 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.

Team members appeared confident when speaking with people. One of the trainee MCAs, when asked, 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. She knew the maximum number of paracetamol tablets which could be sold at any one time and said that she would refer to the pharmacist if a person requested to purchase more than one box of any medicine.

The pharmacists and ACT were aware of the continuing professional development requirement for the professional revalidation process. They had recently undertaken some training provided by the CPPE, including sepsis and 'look alike and sound alike' medicines. The pharmacist said that she recently completed a course about dementia and this was provided by the CPPE. She said that this had given her a better understanding about the different types of dementia and how she might be able to help these people. Team members explained that they did not usually have time during the day to complete training and this was mostly done in their own time. They had been offered the chance to attend training evenings provided by external agencies. Team members planned to attend on about menopause. They said that they would be provided with additional pay and travel allowance if they attended. The pharmacy received a monthly newsletter which highlighted important information and learnings from other pharmacies within the company. Team members signed these to indicate that they had read and understood them.

The second pharmacist said that she felt able to take professional decisions. She said that she had completed declarations of competence and consultation skills for the services offered, as well as associated training. The pre-registration trainee took an active part in the running of the pharmacy. She had recently looked at the training records and implemented a system to ensure that all team members completed any training received from the pharmacy's head office. Team members also discussed any dispensing mistakes openly in the team.

Team members felt comfortable about discussing any issues with the pharmacists or making any suggestions. Some team members had had their appraisals and performance reviews recently and others said that they were due to have theirs soon. They said that these were carried out around once a year. They explained that it was difficult to have meetings where all team members were able to attend, so a record of what was discussed was made available to those not in attendance. This meant that they could also provide feedback and comments about what was discussed.

Targets were set for Medicines Use Reviews and the New Medicine Service. The ACT said that the pharmacy regularly met the targets. The second pharmacist said that she did not feel under pressure to achieve the targets. And she carried out these services for the benefit of the people who used the services.

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. And pharmacy-only medicines were kept behind the counter. 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. There were usually a few team members covering the counter during busier periods which helped to reduce the time people waited to be served.

The consultation rooms were accessible from the shop area and were suitable for the services offered. Low-level conversations in the consultation room could not be heard from the shop area and blinds were used to cover the windows. ‘Engaged/vacant’ signs were available on the doors. The rooms were suitably equipped and accessible to wheelchair users. The rooms were not locked when checked by the inspector. One of the rooms contained some unsecured items. The pre-registration trainee said that the rooms were usually kept locked when not in use and she had recently been using one of them. She locked them the doors and said that she would ensure that these were kept secured in the future.

Toilet facilities and the staff room 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. 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. The MCA checked some medicines which a person was returning to the pharmacy. The person had wanted to return some used sharps, but these were not accepted at the pharmacy so she provided her with the details of the relevant authority to contact.

There were several team members able to carry out blood tests for people taking warfarin, and they had undertaken appropriate training for this. Results were recorded on the patient's medical record and in the person's monitoring record book. And a summary sheet was printed and sent to the person's surgery. The ACT confirmed that results were checked by the pharmacist before they were sent to the surgeries.

The second pharmacist explained how she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. She explained that she had recently given a person an anti-coagulant warning card and discussed someone's blood tests who was taking methotrexate. But she had not recorded any results on the person's medication record. This could make it harder for the pharmacy to know that the person was having blood tests at regular 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. The dispensers said that the pharmacy supplied valproate medicines to a few people. The pre-registration trainee said that there was one person currently in the at-risk group who needed to be on the Pregnancy Prevention Programme. And this had been annotated on their medication record and the risks had been discussed with them. The pharmacy had the relevant patient information leaflets and warning cards available.

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.

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. But 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 and to know that the prescription was in-date when the items were handed out. The dispenser said that uncollected prescriptions were checked regularly and items uncollected after around two months were returned to dispensing stock. She confirmed that she informed the surgery when prescriptions had not been collected and these were then shredded. And other electronic prescriptions were returned to the NHS spine so that these could be re-dispensed if needed.

The ACT said that the regular pharmacist had carried out assessments for some people who had asked to have their medicines in multi-compartment compliance packs and others had been carried out by people's GPs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before they needed their medicines. Packs were assembled in a room adjacent to the dispensary to help minimise distractions. Prescriptions for 'when required' medicines were not routinely requested; the ACT said that people requested prescriptions for these if they needed them with their packs. 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 but the medication descriptions were not recorded on the backing sheets. This made it harder for people to identify their medicines. The ACT said that team members wore gloves and used tweezers to handle medicines when placing them into the trays.

The ACT said that a pharmacist visited the hospice twice a week to carry out clinical checks on the drug charts and had recently written some SOPs for the hospice team members to follow. One of the pharmacy technicians visited the hospice weekly to ensure that they had enough stock. CD medicines for hospice stock were ordered on requisition forms from the pharmacy. 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 ACT 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. The pharmacy's care home co-ordinator and one of the dispensers had visited the care home to discuss the changeover from multi-compartment compliance packs to original pack dispensing. The pre-registration trainee said that two members of the pharmacy team were due to visit the care home once they have transitioned to original pack dispensing to ensure that they received training on the new procedures.

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 and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible. There were multiple people's details on each sheet so the layout might make it harder to ensure that people's details were protected when signatures were recorded. The dispenser said that she would discuss this with the pharmacy manager. 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 and it was being used. Team members had undertaken training on how to use the equipment 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 and separate 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. 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 shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. Equipment used for the INR testing service was regularly calibrated. Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridges were 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.