General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, 5-9 Hawley Street, MARGATE, Kent, CT9 1PU

Pharmacy reference: 1032855

Type of pharmacy: Community

Date of inspection: 01/02/2024

Pharmacy context

The pharmacy is in Margate town centre. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First Service, blood pressure checks and a needle exchange service. It also uses patient group directions for flu vaccinations and a contraception service. The pharmacy provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support. It also provides substance misuse medications to a large 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 appropriately 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. It protects people's personal information. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. The pharmacy 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. The trainee medicines counter assistant (MCA) knew which tasks she should not undertake if the pharmacist was not in the pharmacy, but she thought that she could sell medicines from the general sales list if there was no responsible pharmacist (RP) signed in. The inspector reminded her what she could and couldn't do if the pharmacist had not turned up. The pharmacist said that he would remind all team members about which tasks should not be undertaken if there was no RP signed in.

Team members explained that near misses (dispensing mistakes identified before the medicine had reached a person) were highlighted with them by the person who had checked the medicine. And once the mistake was highlighted, team members were responsible for identifying and rectifying their own mistakes. Near misses were recorded 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. And the outcomes from the reviews were discussed openly during the regular team meetings. Dispensing errors (dispensing mistakes that had reached a person) were recorded on a designated form and a root cause analysis was undertaken. The accuracy checking technician (ACT) said that she was not aware of any recent dispensing errors. Team members said that the patient safety report for near misses and dispensing errors was discussed during the team meetings. And the pharmacy's head office collated information from other pharmacies in the group and learning points shared.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. 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; staff initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). The accuracy checking dispenser explained which prescriptions she could accuracy check, and she knew that she could not check ones she had been involved with dispensing.

The right RP notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any CD 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 routinely recorded. The nature of the emergency was not always recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The pharmacist said that he would ensure that these details were recorded in future.

Confidential waste 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 complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The pharmacy had recently been made aware of a complaint received by its head office. The pharmacy had investigated the complaint and responded to its head office.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. Team members, including the delivery driver had completed training about protecting vulnerable people. Some team members described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. The ACT said that there had not been any recent safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing training to support their learning needs and maintain their knowledge and skills. And 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. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one ACT (who was also the administration manager), three trained dispensers (one was also an accuracy checker) and one trainee MCA working during the inspection. The ACT was responsible for ensuring team members completed the required training and organising planned absences to ensure that there were enough team members working in the pharmacy. And she also helped with the pharmacy's audits. The pharmacy was up to date with its dispensing. Team members worked well together throughout the inspection and they communicated effectively to ensure that tasks were prioritised, and the workload well managed.

The trainee MCA appeared confident when speaking with people. She was aware of which medicines could be abused or may require additional care. And she would refer to the pharmacist if a person regularly requested to purchase these types of medicines. Effective questioning techniques were used to establish whether a medicine was suitable for the person it was intended for.

Team members had access to online training provided by the pharmacy's head office. They could complete training at the pharmacy during quieter periods or at home. The ACT explained that team members had been undertaking some health and safety training, and for the Pharmacy Quality Scheme. And all training required for the Pharmacy First Service. The ACT said that she monitored training and ensured that team members had completed the required training before new services were implemented. And she provided training updates to the pharmacy's head office. The pharmacist and pharmacy technician were aware of the continuing professional development requirement for professional revalidation. The pharmacist felt able to make professional decisions. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacy received a regular newsletter from the pharmacy's head office which included important updates and information about near misses and dispensing errors. There was a weekly huddle so that team members could discuss any ongoing issues, new services, near misses and dispensing errors. Team members had yearly performance reviews. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were set for the New Medicine Service. The pharmacist said that he did not feel under pressure to meet the targets and provided the service for the benefit of the patients.

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 which 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. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The consultation room was accessible to wheelchair users. And it could be accessed from the shop area and the dispensary. It was 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. There were several chairs in the shop area for people to use while they waited. There was a separate counter to the left-hand side of the medicines counter which provided people with more privacy while speaking with the pharmacist or being handed their medicines.

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. And it responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services. But the pharmacy does not always supply patient information leaflets with its multi-compartment compliance packs. So, people may not have all the information they need to take their medicines safely.

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 pharmacy could produce large-print labels for people who needed them.

The pharmacist 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 (PPP). And he would refer people to their GP if they weren't on the PPP and should be. The pharmacist explained how he had undertaken risk assessments if people needed to be supplied a valproate medicine in different packaging from its manufacturer's original full outer packaging. But there was no reference to this on the person's electronic medication record. The pharmacist said that he would ensure that the person's medication record was updated. Prescriptions for Schedule 3 and 4 CDs were highlighted and the 'date not to be handed out after' was recorded. 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 pharmacist said team members checked CDs and fridge items with people when handing them out. Prescriptions for higher-risk medicines were not usually highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that he 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 routinely kept which could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

There were signed in-date patient group directions available for the relevant services offered. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The ACT 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. Items 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.

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 separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. The fridges were suitable for storing medicines and were not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were

recorded. Records indicated that the temperatures were consistently within the recommended range.

One of the dispensers said that uncollected prescriptions were checked regularly, and people were contacted if they had not collected their items after around five weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. 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.

One of the dispensers said that people had assessments to confirm that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. The dispenser said that people usually contacted the pharmacy if they needed their 'when required' 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 suitably labelled, but there was no audit trail to show who had assembled each pack. This could make it harder for the pharmacy to identify who had done this task and limit the opportunities to learn from any mistakes. Medication descriptions were put on the packs to help people and their carers identify the medicines. 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 remind team members to initial the packs when they had assembled a pack and to routinely supply patient information leaflets.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible on a hand-held device. And signatures were recorded in a way so that another person'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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines. 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 ACT said that the blood pressure monitor was replaced in line with the manufacturer's guidance. 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.