General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, 134-136 Delce Road, ROCHESTER, Kent, ME1 2DT

Pharmacy reference: 1032905

Type of pharmacy: Community

Date of inspection: 26/09/2019

Pharmacy context

The pharmacy is located on a small parade of shops surrounded by residential premises. And it is close to two health centres. The people who use the pharmacy are mainly older people. The pharmacy receives around 70% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, flu vaccinations, smoking cessation and blood pressure checks. It supplies medication in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. 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 adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It generally keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted a range of measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Team members had signed the SOPs to indicate that these had been read and understood.

Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. There were a few near misses recorded over the last few months, but the pharmacist said that some had happened which had not been recorded. He said that he would implement a paper near miss log for use during busy periods and ensure that these were regularly recorded onto the electronic system. The pharmacist said that the pharmacy's head office reviewed the near misses and learnings were shared throughout the organisation. Items which 'looked alike or sounded alike' (LASA) were separated where possible to help minimise the chance of the wrong medicine being selected. Shelves where these items were kept were highlighted with the name of the medicines and a red 'LASA alert' sticker was attached to the shelf edge. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong type of medicine had been supplied to a person. The person noticed while in the pharmacy and the correct item was supplied. The medicines were in similar packaging and were kept next to each other on the shelf. The dispenser said that she would separate them and ensure that these were kept separated in future to help minimise the chance of a mistake.

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 asked one of the dispensers to dispense a controlled drug (CD) for him so that he was not dispensing and checking it himself. This helped to minimise the chance of a dispensing error.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that the pharmacy would open if the responsible pharmacist had not turned up but she would not hand out any dispensed items, sell any medicines or carry out any dispensing tasks. She said that she would contact the pharmacy's head office and signpost people to other local pharmacy's if needed. She confirmed that she would not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

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 emergency supply record was completed correctly. There were signed in-date Patient Group Directions for the relevant services offered. And all necessary information was recorded when a supply of an unlicensed medicine was made. The prescriber's details were not always recorded on the private prescription record. This could make it harder for the pharmacy to find these details if there was a future query. CD registers examined were filled in correctly, and the CD running balances were checked regularly. 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 responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2018 to 2019 survey were available on the NHS website. Results were positive and 95% of respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed training provided by the pharmacy's head office. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had been a recent safeguarding concern at the pharmacy. He had referred the concern to the person's GP and the person now had additional help with their medicines. 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 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 pharmacist and three trained dispensers working during the inspection. 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.

The dispensers appeared confident when speaking with people. They were aware of the restrictions on sales of pseudoephedrine containing products. A dispenser 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 completed accredited pharmacy courses for their role. The pharmacist was aware of the Continuing Professional Development requirement for the professional revalidation process. He said that he recently completed the influenza vaccination training and had attended a meeting about Champix. He had completed declarations of competence and consultation skills for the services offered, as well as associated training. The pharmacist kept a record of interventions. A person had recently been prescribed two non-steroidal anti-inflammatories. The pharmacist had contacted the prescriber who had advised that the person should stop taking one of the medicines.

The pharmacist said that team members were provided with some training but this was not regular. He confirmed that he would ensure that all team members were provided with log in details for the online training that was available. The pharmacy's head office offered training evenings provided by external agencies. Team members were provided with additional pay and travel allowance if they attended the events.

Team members had yearly appraisals and performance reviews. The pharmacist said that the pharmacy had regular team meetings and he attempted to arrange them at a time when all team members could attend. He kept a record of what was discussed at the meetings and this was shared with team members who were not able to attend. The pharmacy received a monthly newsletter from the pharmacy's head office with information about common near misses and incidents and updated SOPs. The pharmacist confirmed that he ensured that all team members read these. Team members said that they felt comfortable about discussing any issues with the pharmacist or making any suggestions. .

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist confirmed that he provided these services for the benefit of people who used the pharmacy and would not let the targets affect his professional judgement. He said that he did not feel under pressure and that the pharmacy's head office would provide additional pharmacist support if the pharmacy was not meeting the targets.

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 and a barrier was used to restrict unauthorised access. 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; the room temperature was suitable for storing medicines.

There were six 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 pharmacy had two consultation rooms. Both were accessible to wheelchair users and were located in the shop area. They were suitably equipped, well-screened, and kept secure when not in use. Low-level conversations in the consultation room could not be heard from the shop area. Adrenaline pens and disposable gloves were available if needed.

Toilet facilities and the kitchen area 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. People with a range of needs can access the pharmacy's services. 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. 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. 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 pharmacist said that he sometimes checked monitoring record books for people taking higher-risk medicines such as warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that he would highlight prescriptions for higher-risk medicines in future. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. 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. The pharmacist could not find the warning cards and patient information leaflets that were supplied by the manufacturer. He said that he would order replacements. Most of the sodium valproate boxes with dispensing stock had the warning cards attached.

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 was marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

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. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy kept a record of when manufacturers had been contacted to check the availability of stock, so that people could be informed. Uncollected prescriptions were checked weekly. The dispenser said that items uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber. She said that the NHS electronic system alerted the pharmacy when electronic prescriptions were nearing their expiry date.

The pharmacy was in the process of completing medicines compliance support assessments for people who received their medicines in multi-compartment compliance packs to show that they needed the packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy contacted people to see if they needed them before sending out the packs. 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. Detailed medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

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; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The driver said that he attempted to deliver fridge items at the start of his round. He said that all deliveries were local to the pharmacy and he returned all undelivered items and delivery sheets to the pharmacy before the end of the working day.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. 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 received training and there were written procedures. The pharmacy's head office had supplied an updated SOP and a video for team members to watch.

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 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.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had a sticker indicating that it had been in use since May 2015. The pharmacist said that he would order a replacement. The carbon monoxide testing machine was calibrated by an outside agency. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and 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.