General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Ryders Chemist, 130 High Street, ROCHESTER, Kent, ME1 1JT

**Pharmacy reference:** 1032911

**Type of pharmacy:** Community

**Date of inspection:** 22/08/2024

## Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, and blood pressure checks. And it uses patient group directions for its contraception service, and its flu and COVID vaccination services. The pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

## 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 | 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 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 protects people's personal information well. People can provide feedback about the pharmacy's services. And 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). Team members' roles and responsibilities were specified in the SOPs. Team members were in the process of signing to show that they had read, understood, and agreed to follow the recently updated SOPs. A dispenser said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. And the pharmacy's head office would be informed. She knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Team members explained that near misses (dispensing mistakes which were identified before the medicine had reached a person) were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly with the team. Learning points were also shared with other pharmacies in the group. The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. Previous ones had been recorded on a designated form and a root cause analysis undertaken.

Workspace in the dispensary was limited but it was free from clutter and there were clear areas for dispensing and checking medicines. 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. And team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. 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 private prescription records were largely completed correctly, but the correct prescriber details were not routinely recorded. 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. The importance of maintaining complete records about private prescriptions was discussed with the team.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. And team members had completed training about

protecting people's personal information. Confidential waste was removed by a specialist waste contractor, computers were password protected and people using the pharmacy could not see information on the computer screens.

The pharmacist said that there had not been any recent complaints. She said that the pharmacy would address any complaints and refer them to the pharmacy's head office. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website.

The pharmacist 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. And team members had completed training about protecting vulnerable people. A dispenser described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

Team members do the right training for their roles, and they are provided with some ongoing training to help maintain their knowledge and skills. They can raise concerns to do with the pharmacy or other issues affecting people’s safety. There are enough team members to provide the pharmacy's services safely. And 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 pharmacist explained that holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. 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 pharmacy was up to date with its dispensing.

Team members appeared confident when speaking with people. And they asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. They were aware of the restrictions on sales of pseudoephedrine-containing products. And would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

Team members could complete training at work during quieter periods and they could access the training modules at home. The pharmacy had recently received a training rota from the pharmacy’s head office which meant that in future team members would receive regular protected time to complete the training at work. Team members had recently completed some sore throat and otoscope training. The pharmacist was aware of the continuing professional development requirement for professional revalidation. She explained that she had recently completed some training about hepatitis B, and she was in the process of completing training about the flu vaccination service. The pharmacist felt able to make professional decisions. And she had completed declarations of competence and consultation skills for the services offered and had done the associated training.

Team members explained that information was usually passed on informally during the day. And the pharmacy used a group chat to share information. The pharmacy regularly received a newsletter from the pharmacy’s head office and pharmacy-related updates were available online. Team members could use the pharmacy’s computer to message different teams in the group and this was easy to access. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions. Team members explained that they had informal ongoing performance reviews.

Targets were set for the New Medicines Service and the Pharmacy First service. The pharmacist said that she provided the services for the benefit of the people using the pharmacy and she would not let the targets affect her professional judgement.

## 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 bright, clean, and tidy throughout which presented a professional image. It was secured against unauthorised access and 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 not available in the pharmacy, but the room temperatures on the day of the inspection were suitable for storing medicines. The pharmacist said that the temperatures sometimes went above the recommended maximum on warmer days, and this had been reported to the pharmacy’s head office. She said that she would keep records of the temperatures in future.

There was seating in the shop area for people waiting for services. The consultation room was in the shop area, and it was accessible to wheelchair users. 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. Toilet facilities were clean and not used for storing pharmacy items and there were hand washing facilities available.

## Principle 4 - Services ✔ Standards met

### Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. 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.

### Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter. There was a bell at the door which alerted staff if people needed help to access the pharmacy. 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.

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 3 and 4 CDs were highlighted. This made it easier for team members to check that the prescription was valid at the time of supply. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said team members routinely checked CDs and fridge items with people when handing them out. 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). The pharmacist said that these medicines were supplied in their original packaging. And the pharmacy routinely recorded on the patient medication record if a person was on a PPP or if they did not need to be on one. And the pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that prescriptions for higher-risk medicines would be highlighted in future.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist 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. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging.

CDs were stored in accordance with legal requirements. 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. Fridge temperatures were checked daily, and 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 it was not overstocked.

The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and items were returned to dispensing stock where possible. ‘Owings’ notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. And team members explained that part-dispensed prescriptions were checked daily. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacist said that people had assessments carried out by the pharmacy to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for ‘when required’ medicines were not routinely requested. The pharmacist said that people had to request prescriptions for these medicines if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it 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 pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when assembling the packs. The packs were assembled in a room separate to the main dispensary which helped to minimise distractions.

Deliveries were made by delivery drivers. The pharmacy obtained people’s signatures for deliveries where possible, and these were recorded on a hand-held electronic device so that another person’s information was protected. A card was left at the address asking the person to contact the pharmacy to rearrange delivery if the person was not at home when the delivery attempt was made. And the items were returned to the pharmacy before the end of the working day. The pharmacy could track deliveries which meant that people could find out about the status of their delivery if needed.

## 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 which 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 pharmacist said that the blood pressure monitor was replaced by the pharmacy's head office in line with the manufacturer's guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed. And the weighing scales were in good working order.

## 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. |