General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd, 21-23 London Road, SEVENOAKS, Kent, TN13 1AR

Pharmacy reference: 1032927

Type of pharmacy: Community

Date of inspection: 19/12/2019

Pharmacy context

The pharmacy is located beneath a large surgery, on a busy road near to the main high in a town centre. There are a large number of assisted living flats near to the pharmacy. The people who use the pharmacy are mainly older people. The pharmacy receives around 95% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, NHS health checks and influenza vaccinations. It also provides medicines as part of the Community Pharmacist Consultation Service. It supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And supplies packs to one care home. The pharmacy also 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

Overall, the pharmacy adequately 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. It uses this information to help make its services safer and reduce any future risk. It protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. And team members understand their role in protecting vulnerable people. The pharmacy mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its 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. 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 medicines which 'looked alike or sounded alike' were highlighted. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong quantity of medicine had been supplied to a person. Team members had been reminded to check the seal on the medicine boxes, and if the seal had been broken then they should always check the contents. The incident had been reported to the pharmacy's head office using the pharmacy's online reporting system. Learnings were shared throughout the organisation.

Workspace in the dispensary was largely 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. A quad stamp was used 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 checker knew which prescriptions she could and shouldn't check. And she knew that should not carry out an accuracy check on prescriptions if she had been involved in any part of the dispensing process.

Team members' roles and responsibilities were specified in the SOPs. The dispenser said that he would contact the pharmacy's head office if the pharmacist had not turned up in the morning. He explained that the pharmacy would remain closed and a notice would be displayed informing people about the reason for this. He thought that he could carry out dispensing tasks when there was no RP signed in. The inspector reminded him what he could and couldn't do if the pharmacist had not turned up. The pharmacist said that she would remind all team members about it. The trainee MCA knew that she should not sell any 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 responsible pharmacist (RP) log was completed correctly the right RP notice was clearly

displayed. All necessary information was recorded when a supply of an unlicensed medicine was made and there were signed in-date Patient Group Directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals and at the time of dispensing. 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 there were a few entries where the prescriber's details had not been recorded. 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 the medicine was supplied if there was a query. The regular pharmacist said that she would ensure that the private prescription record and emergency supply record were completed correctly in the future.

Confidential waste was shredded, 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 be viewed by people using the pharmacy, but people's personal information was not visible on them. 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 displayed in the shop area and were available on the NHS website. Results were generally positive and showed that 92% of respondents were satisfied with the staff overall. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area. The locum pharmacist said that there had not been any recent complaints. He explained that he would refer any complaints to the pharmacy's head office if needed.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken safeguarding 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 dispenser 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.

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. 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 locum pharmacist, three trained dispensers, two trainee MCAs working during the inspection. All of the trainee MCAs had worked at the pharmacy for fewer than three months. The pharmacist said that they would all be enrolled on an accredited course before the end of their probation period. Other team members had completed an accredited course for their role and the rest were undertaking training. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The pharmacist explained that one dispenser had left a few months ago and been replaced by a trainee MCA. She said that the trainee MCA was a qualified pharmacist from Spain and there were plans for her to be enrolled on an accredited dispensers course. The pharmacy was relatively busy, and the pharmacist said that she had requested that the trainee MCA spend time in a quieter pharmacy within the organisation so that she could complete the induction course. She felt that a quieter pharmacy would provide a better learning environment. The pharmacy was currently around one day behind with the dispensing. The pharmacist said that the pharmacy had received additional cover from the pharmacy's head office to help. And this was helping them get back up to date.

The trainee MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed 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.

The pharmacists were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist said that team members had access the online training modules. She said that they could access the training at home but did not get time during the working day to complete it. Team members could attend training courses provided by external agencies and the pharmacy's head office would provide additional pay and travel allowance for these events. The pharmacist said that she felt able to take professional decisions. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacist said that the area co-ordinator regularly visited the pharmacy and she felt supported by the pharmacy's head office. Team members had yearly appraisals and performance reviews. There were informal team meetings held each month to discuss any issues and to pass on important information. The pharmacy received a monthly newsletter from the pharmacy's head office.

And team members had signed to show that they had read and understood the content. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

Targets were set for Medicines Use Reviews (MUR) and the New Medicine Service. The pharmacist said that she did not feel under pressure to achieve the targets and carried out the services for the benefit of the people who used the pharmacy. And she would not let them affect her professional judgement. The pharmacist explained that the pharmacy's head office would support the pharmacy if it was struggling to meet the targets and additional pharmacist cover would be provided when needed. She said that there had been some occasions where she had identified people who were not able to attend the pharmacy and an MUR had been carried out over the telephone for these people.

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, but there were some to the left-hand side of the counter which were accessible to people using the pharmacy. The pharmacist said that she was aware of this and would ensure that these were not accessible in the future. The counter was manned by a team member during the inspection. A barrier was used to restrict access to the right-hand side of 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; the room temperature was suitable for storing medicines.

There were four 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. A notice was displayed at the counter asking people to wait to be called forward to the counter. This helped to maintain a bit more privacy at the counter when people were talking.

The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped, well-screened. Low-level conversations in the consultation room could not be heard from the shop area. 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

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. 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 induction hearing loop appeared to be in good working order.

The pharmacy used an appointment system for the health checks. This ensured that there was a member of the pharmacy team available that could carry out the checks. The dispenser had undertaken the training and was in the process of getting her portfolio signed off.

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 she would highlight these prescriptions in the future. The pharmacist said that she did not routinely check monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. This could make it harder for the pharmacy to know that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were highlighted and the date the prescription was no longer valid was recorded on the label. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. 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 relevant patient information leaflets and warning cards were available.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every few 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.

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. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that the uncollected prescriptions had not been checked for several months. There were several prescriptions in the retrieval system which were no longer valid. The pharmacist said that she would ensure that a more reliable system was implemented to help minimise the chance of items being handed out when the prescription was no longer valid. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that assessments were carried out by the pharmacy or the person's GP for people who received their medicines in multi-compartment compliance packs to show that they needed these. 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. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the people requested these 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 they also kept any hospital discharge letters for future reference. Packs were suitably labelled, but there was no audit trail to show who had dispensed each tray. This could make it harder for the pharmacy to identify who had done these tasks and limit the opportunities to learn from any mistakes. The dispenser said that he would initial the trays he had dispensed in the future. 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 disposable gloves when handling medicines that were placed in these packs. The care home was responsible for requesting prescriptions for their residents. The pharmacy received a copy of which items had been ordered and would hasten these with the surgeries if needed.

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, 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 the system worked.

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. Tweezers and disposable gloves 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 blood pressure monitor was replaced at regular intervals. The weighing scales and the shredder were in good working order. The equipment used for the health checks was calibrated monthly. 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.