General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pembury Pharmacy, 5 High Street, Pembury, TUNBRIDGE WELLS, Kent, TN2 4PH

Pharmacy reference: 1033000

Type of pharmacy: Community

Date of inspection: 28/02/2024

Pharmacy context

The pharmacy is in a village on the outskirts of Tunbridge Wells. It provides NHS dispensing services, the New Medicine Service, blood pressure checks, flu vaccinations and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to a large number of people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people.

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 uses this information to help make its services safer and reduce any future risk. It protects people's personal information well. People can feed back about the pharmacy's services. And it largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

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 that he should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. And team members knew which tasks should not be undertaken if there was no responsible pharmacist (RP) signed in.

The admin manager explained how the pharmacy dealt with near misses, where a dispensing mistake was identified before the medicine had reached a person. Near misses 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. Near misses were recorded electronically and were reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Following a recent review of the near misses, amitriptyline had been moved so that it was not kept next to amlodipine. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong bag of medication had been handed out to a person. Team members had been reminded to check the person's details on the prescription and bag label before handing out the items.

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 accuracy checker knew that she should not check any items if she had been involved with dispensing them. A quad stamp was added to prescriptions and dispensing tokens. Team members initialled next to the task they had carried out (dispensed, clinically checked, accuracy checked and handed out). The accuracy checking dispenser knew that she should not check items if she had been involved with dispensing them and she knew which medicines she should not accuracy check.

The RP notice was clearly displayed, and the RP record was completed correctly. The pharmacy had current professional indemnity insurance. 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. 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 nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription records were largely completed correctly, but the full prescriber's details were not always recorded.

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. People's personal information on bagged items waiting collection could not be seen from the shop area. And team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about how people could complain were available in the pharmacy leaflet and were also displayed in the shop area. The admin manager said that there had not been any recent complaints. She would report any complaints to the pharmacy's head office.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. The delivery driver could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist as soon as possible. Team members gave examples of action they had taken in response to safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They 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 any concerns or make suggestions and have regular meetings. 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, three trained dispensers (one was the admin manager and one was an accuracy checking dispenser), two trainee dispensers, one trained MCA and one trainee MCA 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 pharmacy was up to date with its dispensing.

The trainee MCA appeared confident when speaking with people. He was aware of the restrictions on sales of medicines containing pseudoephedrine containing products. And he said that he 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 admin manager explained that team members received monthly online training modules. They could access them at home or in work during quieter periods. The team had recently completed training for the Pharmacy First services. Trainee members of staff were partnered with a trained team member to help support them with their learning.

There were daily huddles so team members could discuss any issues and allocate tasks. The pharmacy received a monthly newsletter from the pharmacy's head office. And there were monthly all staff meetings. The pharmacy had a rota to ensure team members worked in different areas in the pharmacy. This helped to ensure that team members had a varied skills set and could provide cover where needed.

The pharmacist felt able to make professional decisions. And she was aware of the continuing professional development requirement for revalidation. She had completed declarations of competence and consultation skills for the Pharmacy First service, as well as associated training. And she said that she had recently completed a Centre for Pharmacy Postgraduate Education ear nose and throat workshop.

The admin manager said that the company was in the process of changing the way performance reviews were undertaken. She said that these were usually carried out yearly but there had been a slight delay with this year's reviews, and these were due to be undertaken soon. Team members felt comfortable about discussing any issues with the pharmacist. The admin manager said that the compliance officer regularly visited the pharmacy and checked on any issues and internal audit progress.

Targets were set for the New Medicine Service (NMS) and Pharmacy First service. The admin manager said that the pharmacy usually met the NMS target and team members did not feel under pressure to achieve them. She said that the services were provided for the benefit of the people using the pharmacy. And that having a dispenser accuracy checker helped to allow the pharmacist to spend time on clinical 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 which presented a professional image. 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. There was a barrier available to restrict access behind the counter, but this was not in use at the start of the inspection. A team member mentioned that there had been occasions where people using the pharmacy had gone past the counter. The admin manager said that she would remind team members to use the barrier in future. Pharmacy-only medicines were largely kept behind the counter, but some were potentially accessible to the side of the counter. The admin manager placed a temporary barrier in that area and said that she would come up with a more permanent solution.

There were several chairs in the shop area for people to use while waiting. The consultation room was accessible to wheelchair users and was in the shop area. 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. 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. And 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.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with a power assisted door. 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 could produce large-print labels for people who needed them.

Prescriptions for Schedule 3 and 4 CDs were routinely highlighted, and the prescription was annotated with the expiry date of the prescription. This helped minimise the chance of these medicines being supplied when the prescription was no longer valid. Prescriptions for higher-risk medicines were not always highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The admin manager said that she would remind team members to highlight these. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But she said that 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. The pharmacy 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). The admin manager said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy had the patient information leaflets and warning cards available for use with split packs.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The admin manager 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 with a short shelf life were clearly marked. There were no date-expired items found in with dispensing stock during a spot check 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 were recorded in a register and destroyed with a witness, and two signatures were recorded. Expired CDs and CDs that people had returned were clearly marked and separated. Fridge temperatures were checked daily, and 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 were not overstocked. The fridge doors were kept locked when closed to help minimise the risk of the door being left open by accident.

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. Prescriptions were annotated with the date the order for an item had been chased with the supplier. This helped team members to know that the relevant action had been taken and when. The admin manager said that uncollected prescriptions were checked regularly, and people were contacted if they had not collected their items after around six weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The admin manager said that people had assessments 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. Prescriptions for ‘when required’ medicines were not routinely requested. The dispenser said that people usually 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 it 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. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The dispenser wore gloves when handling medicines that were placed in these packs.

Deliveries were made by a delivery driver. The pharmacy obtained people’s signatures for deliveries where possible. Signatures were recorded on a hand-held electronic device which ensured 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. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The delivery driver said that he usually delivered fridge items within the first hour of his route and he returned to the pharmacy frequently throughout the day.

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

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. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only.

Up-to-date reference sources were available in the pharmacy and online. The admin manager 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.