General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Ltd (Scotts), 108 High Street, DOVER, Kent, CT16 1EG

Pharmacy reference: 1085712

Type of pharmacy: Community

Date of inspection: 20/03/2024

Pharmacy context

The pharmacy is on a busy high street adjacent to two surgeries in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and blood pressure checks. It also uses patient group directions to supply influenza vaccinations and contraception. The pharmacy provides substance misuse medications to a small number of people. It supplies medicines in multi-compartment compliance packs to a small number of some people who live in their own homes and need this support. And supplies medicines to some care homes.

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	1.2	Good practice	The pharmacy 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.
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 learns from mistakes that happen during the dispensing process to help make its services safer. And team members understand their role in protecting vulnerable people. People can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And it mostly protects people's personal information.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. And their roles and responsibilities were specified in the SOPs. The accuracy checker said that the pharmacy would open if the pharmacist had not turned up in the morning. And she said that the pharmacy's head office would be informed. She knew which tasks she should not undertake if no responsible pharmacist (RP) was signed in. And she knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

Near misses, where a dispensing mistake was 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. Near misses were recorded and reviewed regularly for any patterns. The pharmacist said that most of the mistakes involved the wrong quantity of a medicine being dispensed. She said that team members were reminded to double check their work before passing to the pharmacist to be checked. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. And the pharmacy's head office was informed. A recent error had occurred where the wrong type of medicine had been supplied to a person. The pharmacist said that the person had been supplied with the right medicine and the person was signposted to another healthcare service. The pharmacy undertook a monthly patient safety review for near misses and dispensing errors. 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.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. There were designated workspaces for dispensing and checking medicines and these were free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks. The pharmacist initialled prescriptions to show that she had clinically checked it. This helped ensure that team members knew which prescriptions had been clinically checked. The accuracy checker knew which prescriptions she should not check, and she knew that she should not check items that she had dispensed.

The pharmacy had current professional indemnity insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. The recorded quantity of one controlled drug (CD) balance checked at random was the same as the physical amount of stock available. The CD running

balances were checked at regular intervals and any liquid overage was recorded in the register. CD registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The private prescription records were largely completed correctly, but the correct prescriber's details were not always 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. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacy manager said that she would remind team members to complete the private prescription record, emergency supply record and CD records properly in future.

Computers were password protected and the people using the pharmacy could not see information on the computer screens. And confidential waste was removed be a specialist waste contractor. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection were kept to the side of the medicines counter. Some people's personal information on bagged items waiting collection could potentially be read by people using the pharmacy. The pharmacy manager said that she would ensure that people's personal information was protected in future.

The accuracy checker said that there had not been any recent complaints. She would refer any complaints to the pharmacy manager. The pharmacy manager said that she would inform the pharmacy's head office if the complaint could not be dealt with in the pharmacy. 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 one the pharmacy's website.

Team members had completed training about protecting vulnerable people. The accuracy checker could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacy manager who could contact the pharmacy's head offices safeguarding lead. The accuracy checker 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 team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they can get time set aside in work to complete it. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets. They can raise any concerns or make suggestions and have regular meetings.

Inspector's evidence

There was one locum pharmacist, one pharmacy technician (who was also the pharmacy manager), one dispenser accuracy checker and one trained medicines counter assistant working during the inspection. The pharmacy manager explained that team members had to apply for leave well in advance and holidays were staggered to ensure that there were enough staff to provide cover. She also explained that there were some team members who would provide cover on their days off if needed. Team members wore smart uniforms with name badges displaying their role. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

The MCA appeared confident when speaking with people. She asked people relevant questions to check whether the medicines were suitable for the person they were intended for. And she was aware of the restrictions on sales of pseudoephedrine-containing products. She said that she would refer to the pharmacist if a person regularly requested to purchase a medicine which could be abused or may require additional care.

Team members completed yearly mandatory training such as manual handling, data protection and infection control. They had access to online training modules which they could complete at the pharmacy when it was quiet, and they could also access them at home. The pharmacy manager explained that she would allow team members dedicated time for training if needed. The pharmacy had a room upstairs available for team members to complete their training. The pharmacist and pharmacy manager were aware of the continuing professional development requirement for professional revalidation. The pharmacy manager had recently undertaken some training about the pharmacy's processes for sending prescriptions to the pharmacy's hub. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to make professional decisions.

The pharmacy manager said that there were informal huddles held each morning so that the daily tasks could be allocated, and any issues discussed. There was a board in the dispensary listing the daily tasks and each team member rotated around so that they remained competent. Team members used a messaging group to share information. The pharmacy manager said that the pharmacy's compliance officer regularly visited the pharmacy. This was to check that team members were following the SOPs and that the pharmacy was operating safely. There was an annual managers' meeting and information was shared throughout the company. The pharmacy received a monthly newsletter from its head office and information was also shared on the pharmacy's social media app. The social media app had documents such as up-to-date SOPs and leave requests. The pharmacy manager said that this made it easier to locate documents and ensured that the most recent one was being used. Team members had

regular performance reviews. And team members felt comfortable about discussing any issues with the pharmacy manager or making any suggestions.

Targets were set for the Pharmacy First service. The pharmacy manager said that the pharmacy did not feel under pressure to achieve its targets. And the pharmacy's head office would provide support if the pharmacy was struggling to meet its targets. The pharmacy manager said that the services were provided for the benefit of the people using the pharmacy.

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. And pharmacy-only medicines were kept behind the counter. Air conditioning was available, and the room temperatures were suitable for storing medicines.

The consultation room was next to the dispensary and behind the medicines counter. It was accessible to wheelchair users, suitably equipped and well screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. The pharmacy manager explained that a member of staff stayed with people when they were using the room. There were some bagged items waiting collection on the way to the room. The pharmacy manager said that the pharmacy was waiting for cabinets to be installed and this would protect the bagged items waiting collection.

There were several chairs in the shop area for people to use while waiting. Toilet facilities were clean and not used for storing pharmacy items and 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 highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. It 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. 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. And the pharmacy could produce large-print labels for people who need them.

There were signed in-date patient group directions available for the relevant services offered. The pharmacy manager said that prescriptions for higher-risk medicines were sometimes highlighted by the pharmacist when they were carrying out the clinical check. Team members knew that this meant that the pharmacist wanted to speak with the person about these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. The pharmacy manager said that team members checked CDs with people when handing them out.

The pharmacy supplied valproate medicines to a few people. There were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy manager said that people would have a risk assessment carried out if they needed to have their medicines out of the original packaging. There were no people in this group at present.

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

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. 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.

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 pharmacy manager said that uncollected prescriptions were checked regularly, and people were routinely contacted if they had not collected their items after two months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacy 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 pharmacy manager said that people usually requested these from their GP 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, but there was no audit trail to show who had dispensed and checked 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 pharmacy manager said that she would get team members to initial the packs when they dispensed them. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The packs were assembled in a room upstairs which helped to minimise distractions. The pharmacy manager said that there were several team members who could assemble the packs. The pharmacy did not order prescriptions on behalf of the care homes. The pharmacy received a list of what had been ordered and checked this against the prescriptions received. The care home was informed ahead of the medicine being dispensed if there were prescriptions missing.

Deliveries were made by a delivery driver. The pharmacy manager said that the driver should be asking for signatures from people, but this had not been happening. She said that she would ensure that signatures were recorded in future. 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. 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. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only.

The otoscope appeared to be in good working order. There was a notice on the box reminding staff to dispose of the specula after one use and this helped to maintain good hygiene standards when using the machine. The blood pressure monitor was replaced in line with the manufacturer’s guidance. And the weighing scales appeared to be in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had up-to-date reference sources available in the pharmacy and online.

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.