General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Paydens Ltd, 6 Liberty Square, Kings Hill, WEST MALLING, Kent, ME19 4AU

**Pharmacy reference:** 1089671

**Type of pharmacy:** Community

**Date of inspection:** 05/09/2022

## Pharmacy context

The pharmacy is located in a shopping precinct in a largely residential area. It provides a range of services, including the New Medicine Service, blood pressure checks, stop smoking service and flu vaccination service (seasonal). And it receives most of its prescriptions electronically. It also provides medicines as part of the Community Pharmacist Consultation Service. And 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.

## 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from its mistakes that happen during the dispensing process to help make its services safer. And it largely keeps its records accurate. The pharmacy mostly protects people's personal information. And team members can deal with any safeguarding concerns properly. The pharmacy ensures that people using the pharmacy know how to make a complaint or provide feedback.

### 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), and reporting and reviewing of dispensing mistakes. And team members had signed to show that they had read, understood, and agreed to follow the SOPs. 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. Team members identified and rectified their own mistakes. Team members were responsible for recording their own near misses on the pharmacy's online reporting system. These were reviewed regularly by the pharmacy's head office 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. And the shelf edges where medicines with similar names or in similar packaging were highlighted. Dispensing errors, where a dispensing mistake had reached a person, were recorded on the pharmacy's online reporting form and a root cause analysis was undertaken. The pharmacy manager said that she was not aware of any recent dispensing errors.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Clear workspaces were used for dispensing and checking to help minimise the chance of errors. And baskets were used to help 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 dispenser knew which prescriptions she could check because the pharmacists initialled the prescriptions that they had clinically checked, and these were kept separated from the other prescriptions. The accuracy checker dispenser knew which medicines she could not check and would pass any prescriptions for these to the pharmacist. The prescriptions waiting to be checked by her were also kept separated to help minimise the chance of the wrong person checking them. She knew that she should not be involved in the dispensing process. And she kept a log of errors that she discovered. She carried out CPD in her own time and kept a record of the training she had undertaken.

Team members' roles and responsibilities were specified in the SOPs. Team members knew which tasks should not be carried out if there was no responsible pharmacist (RP). They would contact the pharmacy's head office if the pharmacist had not turned up in the morning. And the team would signpost people to another local pharmacy if needed. The team also knew that they should not sell any pharmacy-only medicines or hand out dispensed medicines if the RP was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. 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 right responsible pharmacist (RP) notice was clearly displayed and the RP record was largely completed correctly. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. And 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. And 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 ensure that the private prescription record and emergency supply record were completed properly in future.

Confidential waste was either shredded at the pharmacy or 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. A small number of bagged items waiting collection could be viewed by people using the pharmacy. And some people's personal information could potentially be read from the counter. The pharmacy manager said that she would ensure that the bags were turned so that the information was not visible. Team members had completed training about protecting people's information.

The pharmacy had not carried out a patient satisfaction surveys since the start of the pandemic. The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. Team members were not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The pharmacy manager could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And she 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 there were procedures for team members to refer to if needed.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members can take professional decisions to ensure people taking medicines are safe. And these are not affected by the pharmacy's targets. The team are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. But the pharmacy could do more to ensure that team members are enrolled on relevant courses in a timely manner. Team members can raise any concerns or make suggestions.

### Inspector's evidence

There was one pharmacist, one accuracy checker dispenser, four trained dispensers (one had been newly appointed as the pharmacy manager), one trained medicines counter assistant (MCA) and one trainee pharmacist working during the inspection. Most team members had completed an accredited course for their role and the rest had done some training for their role. But one team member had worked part-time at the pharmacy for around two and a half years and he had not been enrolled on an accredited course. The pharmacy manager contacted the pharmacy's head office during the inspection and the inspector received confirmation that the team member had been enrolled on an approved course. The pharmacy manager said that she would ensure that all team members were enrolled on an approved pharmacy course within the required timeframe in future.

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. They appeared confident when speaking with people. And one of the MCA's when asked was aware of the restrictions on sales of pseudoephedrine containing products. He knew which over-the -counter medicines could be abused or may require additional care. And said that he would refer to the pharmacist if a person regularly requested to purchase these medicines. Team members used effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And she had recently undertaken some training about inhaler techniques. The pharmacist said that team members were provided with online training on a regular basis from the pharmacy's head office. Team members could access the training at home but they were sometimes able to do the training modules at work during quieter periods. The pharmacy manager had recently taken over the role and said that she would be monitoring the mandatory training to ensure it was completed in a timely manner.

The pharmacist said that she had completed declarations of competence and consultation skills for the flu service, as well as the necessary associated training. She was waiting to be observed administering some vaccines before she was able to provide the service without supervision.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy manager said that she planned to carry out ongoing informal reviews with team members and formal reviews would be undertaken in around six months. The pharmacist said that she felt able to take professional decisions. Team members had a morning informal huddle to

discuss any issues and allocate tasks.

Targets were set for the New Medicine Service (NMS). The pharmacist said that the pharmacy usually met its targets and one of the dispensers said that the pharmacy had been mentioned in a positive light recently due to the number of NMS completed recently. The pharmacist said that she did not feel under pressure to achieve the targets and carried out the service 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; this presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. 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 were several chairs in the shop area for people to use while waiting. There were three consultation rooms in the shop area. They were all 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. During the inspection, the rooms were not kept secure when not in use. And some medicines inside were potentially accessible. The team said that the items would be moved and kept secured in future and the rooms would be kept locked where possible. There were lockable cabinets in each consultation room and team members found the keys for them during the inspection. 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

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

### 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 pharmacy could produce large-print labels for those people who needed them.

The pharmacy manager said that prescriptions for higher-risk medicines were usually highlighted. But a record of blood test results was not kept at the pharmacy. 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 the local surgery would not usually issue a prescription for someone if they needed to have a blood test. The pharmacy highlighted prescriptions for Schedule 3 CDs but it did not highlight prescriptions for Schedule 4 CDs. This could increase the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacy manager said that team members checked CDs and fridge items with people when handing them out. The pharmacy manager 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 pharmacy did not have the relevant patient information leaflets, warning stickers or additional warning cards available. The pharmacy manager said that she would request these from the manufacturer and ensure that these were supplied when needed.

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 three months were 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 frequently and 'owings' notes were provided when prescriptions could not be dispensed in full. People were kept informed about supply issues and prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked regularly, and people were contacted if they had not collected their medicines after around three 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 carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. 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. And the stock was also ordered at that time to help minimise delays. Prescriptions for 'when required' medicines were not routinely requested. The dispenser said that

people contacted 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 they also kept any hospital discharge letters for future reference. Packs were largely 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 handling medicines that were placed in these packs.

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, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries of CDs 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 via email. The pharmacy manager said that the emails were checked several times a day. And she explained the action taken in response to any alerts or recalls. Any action taken was recorded and kept for future reference which made it easier for the pharmacy to show what it had done in response.

## 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 blood pressure monitor had recently been replaced and the dispenser said that it was replaced yearly. The shredder was in good working order. And the phones in the dispensary were portable so it could be taken to a more private area where needed.

Fridge temperatures were checked daily and the maximum and minimum temperatures were routinely recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridges were suitable for storing medicines and were 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. |