General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Paydens Ltd, Guards Avenue, CATERHAM, Surrey, CR3 5XL

**Pharmacy reference:** 1090013

**Type of pharmacy:** Community

**Date of inspection:** 09/11/2022

## Pharmacy context

This is a busy NHS community pharmacy set next door to a GP surgery in Caterham. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy supplies multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. And people can get a flu jab (vaccination) and have their blood pressure (BP) checked at the pharmacy too.

## 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 appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they review and talk to each other about the mistakes they make. So, they can learn from them and try to stop the same sort of things happening again.

### Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, as a result, it put some plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team had the personal protective equipment they needed. And hand sanitising gel was available for them to use too. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were recently reviewed by the pharmacy's head office. Team members were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. But they hadn't all had the chance to do so. Members of the pharmacy team responsible for making up people's prescriptions kept the dispensing and checking workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the responsible pharmacist (RP). The pharmacy team highlighted and separated medicines which were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Team members discussed and documented the mistakes they made to learn from them and reduce the chances of them happening again. They reviewed their mistakes regularly to help them spot patterns or trends. And, for example, they strengthened their prescription handing out process following some mistakes when they gave out the wrong prescriptions.

The pharmacy displayed a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were also described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. It had an in-store notice which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team made changes to the way it processed people's repeat prescriptions following feedback from some people that it took longer than they were told for their prescriptions to be ready. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept appropriate records of the supplies of the unlicensed medicinal products it made. It had a record to show which pharmacist was the RP and when. And it recorded the emergency supplies it made and the private

prescriptions it supplied on its computer. But the prescriber details were sometimes incomplete in the private prescription records. The pharmacy had a controlled drug (CD) register. And the stock levels recorded in the register were checked as often as the SOPs asked them to be checked. But the details of where a CD came from weren't always completed in full.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed an in-store notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. And it had policies on information governance and safeguarding. Members of the pharmacy team were required to complete safeguarding training relevant to their roles and training on information governance. They had the contacts they needed if they wanted to raise a safeguarding concern. And its team members knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough team members to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

### Inspector's evidence

The regular pharmacy team consisted of a pharmacist manager, a pharmacy technician, three dispensing assistants, three trainee dispensing assistants, two medicines counter assistants (MCAs), two trainee MCAs and four delivery drivers. A relief pharmacist (the RP), three dispensing assistants and three MCAs were working at the time of the inspection. The pharmacy relied upon its team, team members from a neighbouring branch and relief or locum pharmacists to cover absences or provide additional support when the pharmacy was busy. Members of the pharmacy team worked well together. So, people were served promptly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to the pharmacist on duty.

People working at the pharmacy needed to complete mandatory training during their employment. They were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their line manager when they could. They were kept up to date and could share learning from the mistakes they made during regular team meetings. And they were encouraged to complete training when the pharmacy wasn't busy to make sure their knowledge was up to date. Members of the pharmacy team didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led them to review and improve the way in which they processed people's repeat prescriptions.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy provides an adequate and a secure environment to deliver it services from. And people can receive services in private when they need to.

### Inspector's evidence

The pharmacy premises were air-conditioned, bright, clean, secure and tidy. They were organised and professionally presented. The pharmacy generally had the workbench and storage space it needed for its current workload. The pharmacy had an appropriately-sized consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they regularly wiped and disinfected the surfaces they and other people touched.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy has working practices that are generally safe and effective. And its team is friendly and tries to help people access its services. Members of the pharmacy team generally dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy offers flu jabs and keeps appropriate records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources. And it mostly stores them appropriately and securely.

### Inspector's evidence

The pharmacy had a wide entrance which was level with the outside pavement. But its automated door wasn't working at the time of the inspection. So, a member of the pharmacy team opened the door when necessary to help people with pushchairs or who used wheelchairs or mobility scooters enter the building. The pharmacy had some notices that told people about its products and the services it delivered. It had a seating area for people to use if they wanted to wait. And this was set away from the counter to help keep people apart. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could help and advise them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept an audit trail to show when it delivered someone their medicines. But its delivery team didn't routinely ask people to sign to say they had received their medicines as required by the SOPs. The pharmacy dealt with CPCS referrals especially when other pharmacies or people's GP surgeries were busy or closed. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And the pressure on local surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses was reduced too. The pharmacy had the anaphylaxis resources and the patient group directions it needed for its weekly flu jab service. And the pharmacy team members who vaccinated people were appropriately trained. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacist generally asked another team member to check that the correct vaccine had been selected before administering it. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were routinely supplied. So, people had the information they needed to make sure they took their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert the team member when these items needed to be added or if extra counselling, such as with medicines used to thin people's blood, was needed. And assembled CD prescriptions awaiting collection were marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention

programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And they had the resources they needed when they dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. But some medicines weren't in their original packaging. This made if difficult for the pharmacy team to tell if it had all the information needed if a particular make of medicine was recalled. Members of the pharmacy team marked containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines at regular intervals and recorded these. And they also marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in an appropriate pharmaceutical waste bin. But pharmaceutical waste had been allowed to build up and was kept in the toilet. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

### Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact head office or the National Pharmacy Association to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. The pharmacy periodically sent its BP monitors to head office to be calibrated. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

## 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. |