General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Park Pharmacy, 102 Kings Road, HERNE BAY, Kent, CT6 5RE

Pharmacy reference: 1092815

Type of pharmacy: Community

Date of inspection: 15/03/2024

Pharmacy context

The pharmacy is on a main road near Herne Bay seafront. It provides NHS dispensing services, the New Medicine Service, blood pressure checks, and the Pharmacy First service. And it uses patient group directions for its flu and chlamydia services. And it also 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

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. It protects people's personal information well. And people can provide feedback about the pharmacy's services. 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). Team members' roles and responsibilities were specified in the SOPs, and they had signed to show that they had read, understood, and agreed to follow them. Team members said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They would attempt to contact the pharmacist and would inform the pharmacy's head office if needed. They knew that they 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. 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 outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. The pharmacy used a messaging app to share pictures of medicines in similar packaging. 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 type of medicine had been supplied to a person. The person was given the right medicine and the pharmacy's head office was informed.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. Workspace in the dispensary was free from clutter and there were designated areas for dispensing and checking medicines. Baskets were used to help 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 in the 'clinically checked ' box on prescriptions and dispensing tokens. The dispenser accuracy checker knew that she could only undertake an accuracy check on a prescription that had been clinically checked by the pharmacist. She gave an example of medicines that she could not check, including controlled drugs (CDs) and higher-risk medicines. And she knew that she should not check a medicine if she had been involved with dispensing it.

The pharmacy had current professional indemnity insurance. CD registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any 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 right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. The private prescription records were largely completed correctly, but the prescriber's details were not routinely 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. The pharmacist said that he would remind team members to record these details in private prescription and emergency supply records in future.

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. Bagged items waiting collection could not be viewed by people using the pharmacy.

Team members were not aware of any recent complaints. The pharmacy's complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Team members said that they would refer any complaints to the pharmacist or admin manager. One of the team said that the pharmacy's head office would inform the pharmacy if it received any complaints directly.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some training about protecting vulnerable people. Team members could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

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. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. And they can raise concerns to do with the pharmacy or other issues affecting people's safety. 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, six trained dispensers (one was an accuracy checker, and one was the admin manager) and two trainee dispensers working during the inspection. The pharmacy was up to date with its dispensing. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

Team members appeared confident when speaking with people and they asked relevant questions to establish whether a medicine was suitable for the person it was intended for. They knew the restrictions on sales of medicines containing pseudoephedrine. They knew to refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care.

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some from the pharmacy's head office. Team members had recently completed training for the Pharmacy First service and for the Pharmacy Quality Scheme. Team members said that they were allowed time at work to complete training. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had recently completed refresher training for the flu vaccination service and some contraception training. He felt able to make professional decisions. And 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 the admin manager. The pharmacy had informal huddles in the morning to discuss issues and allocate tasks. Targets were not set for team members. The pharmacist said that the New Medicines Service and Pharmacy First service were provided for the benefit of the people who used 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 bright, clean, and tidy throughout which presented a professional image. And it was secured from unauthorised access. 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 temperature was suitable for storing medicines.

There were several chairs in the shop area for people to use while they waited. The consultation room was accessible to wheelchair users, and it could be accessed from the dispensary and 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

People with a range of needs can access the pharmacy's services. 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. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity 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 pharmacy could produce large-print labels for people who needed them.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. He said that the pharmacy had recently undertaken an audit and found that most people had in-date blood test results. And he said that the surgeries usually would not issue a prescription if a person needed a blood test. 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. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said CDs and fridge items were checked with people when handing them out. 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 pharmacist said that the pharmacy supplied these medicines in original full packs only. And he would refer people to their GP if they needed to be on the PPP and weren't on one. There were signed in-date patient group directions available for the relevant services offered.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. And items with a short expiry date 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. 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.

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. 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 kept separated from CD dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacist said that uncollected prescriptions were checked regularly, and people were usually

contacted if they had not collected their items after around four weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked daily. '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.

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. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery. The driver had done safeguarding training and said that she would contact the pharmacy or emergency services if needed.

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 which helped avoid any cross-contamination. Suitable equipment for measuring liquids was available and separate liquid measures were used to measure certain medicines only. 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 was replaced by the pharmacy’s head office in line with the manufacturer’s guidance. The weighing scales were in good working order. And 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.