

Registered pharmacy inspection report

Pharmacy Name: Petts Wood Pharmacy, 83 Queensway, Petts Wood, ORPINGTON, Kent, BR5 1DQ

Pharmacy reference: 1093087

Type of pharmacy: Community

Date of inspection: 05/05/2021

Pharmacy context

This is a community pharmacy on a High Street, and the pharmacy is open extended hours. Its main activity is dispensing NHS prescriptions, and it has a dispensing robot. The pharmacy also supplies medicines in multi-compartment compliance packs to some people who need help taking their medicines. And it provides the New Medicine Service. It had provided travel vaccinations before the Covid-19 pandemic. The inspection was undertaken during the Covid-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy doesn't always make sure that staff do the required accredited training for their roles.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn't always store its medicines securely or in a tidy manner.
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. Staff know about their own roles and responsibilities, and they work to written procedures. They know about their role in protecting vulnerable people. The pharmacy largely keeps the records it needs to by law, to show that medicines are supplied safely and legally. And it generally protects people's personal information well. People using the pharmacy are able to provide feedback or raise concerns.

Inspector's evidence

A selection of standard operating procedures (SOPs) was examined. They were in date, and staff had signed to indicate that they had read and understood them. The trainee dispenser was able to explain what he could and couldn't do if the Responsible Pharmacist (RP) had not turned up in the morning. And what steps to take if someone came in repeatedly for a medicine that could be misused.

Dispensing mistakes that had been identified before they were handed to a person (near misses) had not been recorded for around two years. The RP believed that some near misses had occurred in that time, but they had not been recorded. He said it was possible that the manager (not present during the inspection) kept some additional records. The RP did give an example of a near miss that had occurred between Alfamino and Althera, where the names and packaging were similar. And he showed that the different brands had been separated on the shelves. The RP was not aware of any dispensing mistakes where the medicine had reached a person (dispensing errors) that had happened recently. He was able to show how he would record a dispensing error on an electronic reporting system on the pharmacy's computer. No regular review of dispensing mistakes took place, which could mean that staff miss out on opportunities to make the pharmacy's systems safer.

Clear plastic screens had been installed on the counter to help prevent the spread of infection during the pandemic. Staff had all received at least one vaccination for Covid-19 and were seen wearing face masks if they needed to go into the public area. Earlier in the pandemic the pharmacy had limited the number of people allowed in at one time, but at the start of the inspection there were seven people in the pharmacy. However, they were able to keep a one metre distance from each other. This was discussed with the RP during the inspection. The RP confirmed that risk assessments had been done for staff in relation to Covid-19.

Prior to the pandemic, the pharmacy had done an annual patient survey. People could leave feedback via the pharmacy's website or in person at the pharmacy counter. There was a sign explaining to people how they could provide feedback or make a complaint, but the sign was badly damaged and not very visible. The RP said that a new sign would be printed out.

The pharmacy's indemnity insurance certificate on display in the dispensary had expired, but the insurance provider confirmed that the pharmacy had current cover. Private prescription records were kept in paper and electronic format, and the electronic records seen complied with requirements. Records for emergency supplies of prescription-only medicines seen were complete. Records of unlicensed medicines supplied did not always contain all the required information, and this was discussed with the RP. Controlled drug (CD) registers examined had been largely filled in correctly, although some page headings were missing. CD running balances were usually checked regularly, but

this had occasionally not occurred during the pandemic. A random check of a CD medicine showed that the quantity of stock matched the recorded balance.

No confidential information was visible from the public area, and this was an improvement from the previous inspection. A shredder was used to dispose of confidential waste, but one dispensing label was found in general waste and this was immediately removed. Staff were aware of the importance of protecting people's personal information. The RP confirmed he had completed the level 2 safeguarding training and with some prompting, he could explain what he would do if he had any concerns about a vulnerable person. Staff had read through and signed the safeguarding SOP, and the RP said that they had completed the level 1 safeguarding training.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has just enough staff for its services and workload. But it doesn't always make sure that staff do the required training for their roles. Staff are able to raise concerns or make suggestions to help improve the pharmacy's services. They get some ongoing training to help keep their knowledge and skills up to date, but this has been affected by the pandemic.

Inspector's evidence

At the time of the inspection there was the RP, two trainee dispensers, and a new member of staff who had started work at the pharmacy the previous day. There was also a team member working on the medicines counter who had worked in the pharmacy for around six months but had not yet started an accredited training course. And the RP said that there was also another team member working for the pharmacy who was in a similar position, but they were on a day off on the day of the inspection.

The pharmacy's workload was largely up to date, although the prescriptions from the previous day were still being dispensed. The pharmacy was in the process of advertising for another member of staff, preferably one who had completed an accredited dispenser or technician course.

Staff received some informal ongoing training, such as updates to new medicines or products. Or when seasonal ailments such as hayfever started. No formal records were made of this ongoing training. Team members had access to pharmacy magazines and literature from manufacturers. A team member said that the pandemic had made it harder to find time to do ongoing training.

Staff felt comfortable about raising any concerns or making suggestions, and the pharmacy had a whistleblowing policy. The RP felt able to take any professional decisions. There were no formal targets in place for team members.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are adequate for the pharmacy's services, and they are kept secure from unauthorised access when the pharmacy is closed. People can have a conversation with a team member in a private area. The pharmacy has limited storage space and could do more to keep all areas clean and tidy.

Inspector's evidence

The premises were of an average size, but the dispensing robot took up a large space in the dispensary, which left a narrow corridor for staff to be able to move around. There was a small room at the back of the pharmacy which was mainly used for stock storage and the dispensing of multi-compartment compliance packs. There was an adequate amount of clear dispensing space, but the pharmacy itself was untidy in places, and there was a large amount of stock (see Principle 4).

The pharmacy had a consultation room which allowed people to have a conversation inside which would not be overheard. The room had lockable cupboards for storing items in. The room itself was not very tidy, which gave an unprofessional appearance. Lighting throughout the pharmacy was good, and the premises were protected from unauthorised access when the pharmacy was closed. Parts of the dispensary floor required cleaning, and the RP said that this would be done.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy gets its medicines from reputable sources, but it doesn't always store them securely or keep them tidy. Otherwise, the pharmacy generally provides its services safely and manages them adequately. People with different needs can access the pharmacy's services. The pharmacy takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had step-free access from the street via an automatic door. Television screens in the window displayed a rotating list of the services the pharmacy provided. And the pharmacy was open for extended hours.

Dispensed multi-compartment compliance packs examined were labelled with a description of the medicines inside, to help people and their carers identify them. An audit trail was used to show who had done the dispensing and checking of the packs. Patient information leaflets were supplied regularly, so that people had the information they needed to take their medicines safely. People were assessed to see if the packs were suitable for them by an external organisation, who then made a referral to the pharmacy if required.

An electronic audit trail was used for deliveries of medicines to people's homes, and the staff could access this on the pharmacy's computer system. People receiving medicines were no longer signing for them, and instead, to help with infection control during the pandemic, the driver signed to indicate the medicines had been safely delivered.

A selection of patient group directions (PGDs) was examined, and there were signed in-date copies available on the pharmacy's computer system. The RP said that he was due to retake the online training for the PGDs so he was not currently using them.

Dispensed prescriptions for higher-risk medicines were not routinely highlighted, although there were no examples found on the shelves. The RP explained that the pharmacists were personally involved when medicines were handed out, and he would use this opportunity to pass on any information people needed to know. When a person came in to collect a medicine, counter staff were seen to hang a note up in the dispensary with the person's name on it. And then the pharmacist found the dispensed items and reviewed them before the medicines were handed to the person. Staff were aware of the additional information about pregnancy prevention that needed to be provided to some people taking valproate medicines. The required warning cards were seen to be attached to the manufacturers' packs.

The pharmacy obtained its medicines from licensed wholesale dealers and specials suppliers. But it did not always store its medicines in a tidy manner and there were very large amounts of stock for such limited storage space. The dispensing robot held a number of commonly used medicines, but shelves in the back room were very full. On the top shelves, there were bundles of medicines protruding from the shelves, which could cause a risk for the staff if they fell off. Behind the pharmacy counter, there were boxes full of medicines, which limited the space staff had. Not all the pharmacy's medicines were stored

securely.

Some CDs were not stored in accordance with legal requirements. Following the inspection, the RP confirmed that this had been resolved. Liquids with limited shelf lives when opened were not always marked with the date of opening. And this could make it harder for staff to know if they were still suitable to use. Items such as dressings and food supplements were stored in a large outhouse outside. Following previous inspections, this was now kept locked. A date-checking procedure was in place and this was largely supported with records. The records for the date checks in the outhouse were not up to date. But the RP said that the date checks had been done. Samples of stock in the dispensary and outhouse were examined, and no date-expired medicines were found. Medicines requiring cold storage were stored in a fridge and the temperatures were recorded daily. Temperature records seen were within the required range. Medicines for destruction had been separated from stock and placed into designated bins. But the bins were not always stored securely. The RP explained that he had arranged for these medicines to be collected more frequently to help avoid them building up.

The RP described the actions that were taken if the pharmacy received a safety alert or a medicine recall. He was unable to show any recent records and believed that the manager had stored them somewhere. Not having the records to hand could make it harder for the pharmacy to show what action it had taken 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

There were calibrated glass measures, and some measures were marked for use with certain liquids. Some of the measures required cleaning, which the staff said would be done. The electronic tablet counter was covered in tablet dust, but it was rarely used. Staff said that they would ensure it was cleaned before it was used again. The robot was maintained under a maintenance contract. The shredder was in working order, and the phone was cordless and could be moved to a more private area to help protect people's personal information. The travel vaccination service was not operating due to the pandemic. And the RP explained that when it was operational, he always had access to an anaphylaxis kit.

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.