General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Penenden Heath Pharmacy, 321 Boxley Road, Penenden Heath, MAIDSTONE, Kent, ME14 2HN

Pharmacy reference: 1118607

Type of pharmacy: Community

Date of inspection: 31/08/2022

Pharmacy context

The pharmacy is in a post office on a parade of shops in a largely residential area. It provides a range of services, including the New Medicine Service and flu vaccinations (seasonal). And it also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it receives most of its prescriptions electronically.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

Team members understand their role in protecting vulnerable people. And overall, the pharmacy adequately identifies and manages the risks associated with its services. The pharmacy mostly keeps the records it needs to keep by law. And it largely protects people's personal information.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) were kept on the pharmacy's computer system. The pharmacist showed how team members could complete tests to show that they had understood the processes in the SOPs. And this was due to be implemented shortly. A team member explained how near misses, where a dispensing mistake was identified before the medicine had reached a person, were dealt with. The near misses 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. The pharmacist said near misses had not been recorded recently and he planned to implement a recording and review process to help identify any patterns. He said that he had discussed with the team about the importance of separating items in similar packaging or with similar names 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. A recent error had occurred where the wrong strength of medicine had been supplied to a person. Team members were reminded to take care when selecting medicines.

Workspace in the dispensary was limited but there was clear space for team members to dispense and check medicines. And an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled dispensing labels to show who had dispensed and checked each medicine.

Team members' roles and responsibilities were specified in the pharmacy's SOPs. Team members could access the pharmacy if the pharmacist had not turned up in the morning. But trainee dispenser knew that he should not sell any medicines or hand out bagged items if there was no responsible pharmacist (RP) signed in. And he knew which tasks should not be undertaken if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the date on the prescription and the prescriber details were not routinely recorded. 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. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. And there were several registers with loose leaves. The pharmacist said that he would ensure that these were attached properly to help minimise the chance of them becoming lost. CD running balances were checked at regular intervals and 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. There were a few

missed entries on the RP record, the pharmacist said that he would ensure that it was completed properly 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. At the start of the inspection, team members were using a smartcard to access the NHS electronic system. And the smartcard being used belonged to a team members that was not working at the pharmacy at the time. Team members said that he had been working at the pharmacy recently and he was due to return to the pharmacy shortly. The inspector discussed the use of smartcards with the pharmacist and he explained that the trainee pharmacist's card had been requested and the trainee dispenser would have one after his probationary period had ended. The pharmacist had forgotten to bring his own card with him to the pharmacy.

The pharmacist said that the pharmacy had previously carried out patient satisfaction surveys, but it had not carried one out since the start of the pandemic. The pharmacy technician was not aware of any recent complaints. The complaints procedure was available for team members to follow if needed.

The pharmacist and pharmacy technician had completed the Centre for Pharmacy Postgraduate Education Level 3 training about protecting vulnerable people. The trainee pharmacist could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy technician said that there had not been any safeguarding concerns at the pharmacy. And 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 training for their roles. And they are able to discuss any issues openly.

Inspector's evidence

There was one pharmacist (who was also the superintendent), one trainee pharmacist and one trainee dispenser working at the start of the inspection. The pharmacy technician (who was the operations manager for the pharmacy group) arrived at the pharmacy during the inspection. He said that he was helping out until the pharmacy had employed another team member. The trainee dispenser had worked at the pharmacy for around two months. The pharmacist said that he would ensure that the trainee dispenser was enrolled on an accredited course for his role within the required timeframe. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

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

The pharmacist felt able to take professional decisions. He and the pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. And they had recently undertaken training about the Covid vaccination service. The pharmacy technician said that he was mentoring two of the NVQ level 3 students who worked at a different pharmacy. Team members were provided with some training which included the pharmacist passing on information informally to them. But there was no current structured training plan.

There were regular informal huddles held in the pharmacy to allow team members to discuss any issues and allocate tasks. Team members felt comfortable about having open discussions with the pharmacist pharmacy technician or suggesting changes. The pharmacy technician said that team members had regular ongoing informal performance reviews and a formal review yearly.

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 currently shared the building with a Post Office and a convenience store. The pharmacy premises was secured from unauthorised access. It was bright, clean, and tidy throughout. Pharmacy-only medicines were kept behind the counter. 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. Air conditioning was available and the room temperature was suitable for storing medicines. Some bags of dispensed medicines were stored in an area to which people using the pharmacy potentially had access, and some people's details could be seen on the bags. There was a barrier available to use to restrict access to this area and the pharmacist said that he would ensure that this was used in future. And he said that people’s information would be protected.

The consultation room was accessible to wheelchair users and was accessible from the shop area and from the dispensary. 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 gets its medicines from reputable suppliers and largely 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. Overall, the pharmacy provides its services safely and manages them well. But the pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities 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 pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. 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 pharmacist said that dispensed CDs and fridge items were checked with people when handed 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. The pharmacy did not have the additional warning stickers or patient information leaflets available. And team members were not aware that the warning cards attached to the medication boxes could be removed to allow space to attach the dispensing label without covering up the warnings. The pharmacist said that he would order the additional warning stickers and patient information booklets from the medicine manufacturer. And ensure that these were routinely supplied to people with their medicine.

Stock was stored in an organised manner in the dispensary. The pharmacist explained that the pharmacy was in the process of carrying out a full expiry date check as this had not been carried out for some time. Several medicines were found which were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

The pharmacist said that uncollected prescriptions were checked regularly. Items remaining uncollected after around two months were returned to dispensing stock where possible. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber. 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 pharmacist said that people had had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. He explained that he had reviewed the system for managing the prescriptions for the packs and changed it to ensure that prescriptions were ordered in advance. This meant that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The pharmacist said that the pharmacy sometimes contacted people to ask if they needed them when their packs were due, or people would contact the pharmacy to request these. The pharmacy kept a record for each person which included any changes to their medication. Packs were 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. But the patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The pharmacist said that he would ensure that the information leaflets were supplied with the packs in future.

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 did not currently obtain people's signatures for most of the deliveries to help minimise the spread of infection. The pharmacist explained that the pharmacy would start obtaining signatures for deliveries and showed the inspector the proposed signature sheet. There were multiple people's details on each sheet and it would be difficult to obtain signatures while covering other people's details. The inspector discussed this with the pharmacist during the inspection and he said that he would change the signing sheet so that people's details were not visible to others. The pharmacist said that a card asking for the person to rearrange delivery was left at the person's address if they were not at home. And the medicines were returned to the pharmacy.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But a record of any action taken was not kept and this could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would ensure that a record of the action taken was kept in future.

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

The pharmacy had suitable equipment for measuring liquids was available but not for volumes less than 10 millilitres. The pharmacist said that he would ensure that a measure was ordered. Triangle tablet counters were available, but there was a layer of powder residue on them. The trainee dispenser said that he would ensure that these were cleaned regularly. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. There were up-to-date reference sources in the pharmacy and team members could also access these online. The phone in the dispensary was portable so it could be taken to a more private area where needed.

The pharmacist explained that the fridge temperatures were checked daily, but the maximum and minimum temperatures were not routinely recorded. The maximum temperature was outside the recommended range, but the current temperature was within the range. The pharmacist said that he would ensure that the temperatures were checked and recorded daily. The fridge was suitable for storing medicines and it was 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.