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: 15/08/2024

Pharmacy context

The pharmacy is in a shop on a parade of shops in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to some people who live in their own homes and need this support. And it supplies medicines to a small number of care homes. The pharmacy had changed ownership around two weeks prior to the inspection.

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

The pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. 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 team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). The pharmacist said that the superintendent pharmacist was in the process of updating them. She said that team members would then sign to show that they had read, understood, and agreed to follow them. The dispenser said that the shop would open but the dispensary would remain closed if the pharmacist had not turned up in the morning. The medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items it the pharmacist was not in the pharmacy.

The pharmacist said that 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. Once the mistake was highlighted, team members were responsible for identifying and rectifying them. And near misses were routinely recorded. The pharmacist said that the record would be 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. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints.

Workspace in the dispensary was limited but it was free from clutter. And there was 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. Team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The pharmacist said that the pharmacy did not supply prescription-only medicines in an emergency without a prescription. She said that people were signposted to NHS 111 to request these. 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. But there were several occasions recently where the pharmacist had not completed the record when they had finished their shift and a different pharmacist was working the following day. The pharmacist said that she would remind people to complete the record correctly in future. The private prescription records were mostly completed correctly, but the prescriber's details were not routinely recorded. The importance of maintaining complete records about private prescriptions was discussed with the team.

People's personal information on bagged items waiting collection could not be viewed by people using

the pharmacy. Computers were password protected and people using the pharmacy could not see information on the computer screens. And confidential waste was removed by a specialist waste contractor. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

Team members had completed training about protecting vulnerable people. The MCA 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. 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 and they do the right training for their role. Team members can raise any concerns or make suggestions. And they can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, one trained dispenser and one trained MCA working during the inspection. There were contingency arrangements for pharmacist cover if needed. The pharmacist explained that holidays were staggered to ensure that there were enough staff to provide cover. Team members communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was up to date with its dispensing.

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

The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. The pharmacist was aware of the continuing professional development requirement for revalidation. She had recently undertaken training for the Pharmacy First service and for flu vaccinations. And she had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team member said that there was a team meeting held when the pharmacy changed ownership and she planned to have regular meetings going forward. Pharmacy related information was passed on informally during the day. Team members prioritised and allocated tasks and discussed any issues during the morning huddles. The pharmacist said she felt able to make professional decisions. The pharmacist said that currently, team members had ongoing informal performance reviews, but these would be formalised soon. The pharmacy was family run and team members felt comfortable discussing any issues with the pharmacists. Targets were not set for team members. The pharmacist said that the services were provided 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 against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the dispensary 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.

The consultation room was accessible to wheelchair users and could be accessed from the shop area and 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

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. 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

Services and opening times were clearly advertised, and a variety of health information leaflets was available. And the pharmacy could produce large-print labels for people that needed them. There was step-free access into 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.

Prescriptions for Schedule 3 and 4 CDs were routinely highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Team members checked CDs and fridge items with people when handing them out. The pharmacist 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 (PPP). The pharmacist said that she would refer people to their GP if they needed to be on the PPP and weren't on one. And she explained that the pharmacy dispensed valproate medicines in their original packs. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. The pharmacist said that she would highlight these in future. She said that if she handed out a higher-risk medicine she would ask the person about their recent blood test results. But a record of blood test results was not kept. And this could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. Stock due to expire within the next six months was marked. There were no date-expired items found in with dispensing stock during a random spot check and medicines were kept in their original packaging. The pharmacy kept lists of short-dated items, and these were removed from dispensing stock around one month before they were due to expire. 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. 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 fridge was suitable for storing medicines and it was not overstocked. CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. And returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The MCA said that uncollected prescriptions were checked regularly, and people were contacted if they had not collected their items after around four to six 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. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Prescriptions for alternate medicines were requested from prescribers where needed. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues.

The pharmacist said that people had assessments 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. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people contacted the pharmacy if they needed these medicines when their packs were due. Packs were suitably labelled but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. The packs were managed by one of the dispensers who had worked at the pharmacy before the change of ownership. The pharmacist said that other team members were learning the process so that cover could be provided if needed.

The pharmacist explained that the pharmacy provided a delivery service for people who were not able to collect their items from the pharmacy. Deliveries were made by one of the dispensers and the pharmacy was in the process of recruiting a delivery driver. The pharmacy obtained signatures for items delivered to the care homes and for CDs. The pharmacist said that the pharmacy would obtain signatures for all deliveries in future and ensure that people's personal information was protected. The dispenser said that the was in the process of creating a 'failed delivery' note to inform people that a delivery attempt had been made.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its equipment to help protect people's personal information. And it largely has the equipment it needs to provide its services safely.

Inspector's evidence

Triangle tablet counters were available and clean, and a separate counter was marked for cytotoxic use only. This 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. Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. The pharmacist said that she would order a suitable measure.

The blood pressure monitor had been in use for less than one year. The pharmacist said that it would be replaced in line with the manufacturer's guidance. The phone in the dispensary was portable so it could be taken to a more private area where needed. Up-to-date reference sources were available in the pharmacy and online.

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.