General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Paydens Pharmacy/Express Chemist, I P S House, Wallis Avenue, MAIDSTONE, Kent, ME15 9NE

Pharmacy reference: 1123025

Type of pharmacy: Internet / distance selling

Date of inspection: 18/11/2019

Pharmacy context

This is a pharmacy which offers a 'hub and spoke' service for other pharmacies in the group and also supplies medicines online. It supplies multi-compartment compliance packs to several other pharmacies in the group. These pharmacies then supply these packs to people who live in their own homes to help them manage their medicines. The pharmacy also supplies medicines in their original packs to care homes directly. The pharmacy holds a wholesale dealers licence and a Home Office license which allows it to supply some medicines to the care homes. It sells medicines online, and this includes pharmacy-only and General Sales List medicines. It receives nearly all of its prescriptions electronically and also dispenses against a small number of private prescriptions. And it offers a range of other services including Medicines Use Reviews, the New Medicine Service and seasonal influenza vaccinations.

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 protects people's personal information well and it regularly seeks feedback from people who use the pharmacy. It largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included; documented, up-to-date standard operating procedures (SOPs), and to some extent, near miss and dispensing incident reporting and review processes. Team members had signed to show that they had read and understood the SOPs. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were not always recorded, but the ones that were had been reviewed for any patterns. The pharmacist said that he was in the process of implementing a more reliable system for team members to record their own near misses. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And shelf edges were highlighted to show where medicines in with similar names were kept. The pharmacy highlighted where medicines which 'looked alike or sounded alike' were kept. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The person had noticed the error before taking the medicine and the correct item was supplied. A report had been completed and the pharmacy's head office had been informed.

Workspace in the dispensary was free from clutter. 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. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checking technician (ACT) explained that a black ink was used to initial the dispensing label in the 'dispensed by' box and coloured pen when it had been checked. The accuracy checkers knew which prescriptions they could check and they knew that they should not check items if they had dispensed them.

Team members' roles and responsibilities were specified in the SOPs. The pharmacist explained that team members had access to the pharmacy if the pharmacist had not turned up. He said that there were several pharmacists that worked in the pharmacy's head office in the building next to the pharmacy and they could provide cover where needed. The ACT said that she would not carry out any dispensing or checking tasks until there was a responsible pharmacist signed in.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date Patient Group Directions available for the influenza vaccination service. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked frequently. The recorded quantity of one CD item checked at random was the same as the

physical amount of stock available. The responsible pharmacist (RP) log was completed correctly and the correct RP notice was clearly displayed. The private prescription record was largely completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The ACT explained that the pharmacy only made supplies against private prescriptions when the pharmacy had received the original prescription.

Patient confidentiality was protected using a range of measures. Confidential waste was shredded, 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. The pharmacy team members had completed training about the General Data Protection Regulation. The pharmacy's privacy policy was displayed on its website which explained how the pharmacy kept people's personal information secured.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 to 2020 survey were available on the NHS website. Results showed that 100% of respondents were satisfied with the pharmacy overall. The complaints procedure was available for team members to follow if needed and details about it was available on the pharmacy website. The ACT said that the pharmacy had not received any complaints. The website had the contact details for the pharmacy and information about how people could provide feedback about its services.

The pharmacists and the ACT had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The ACT could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She 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 trained team members to provide its services safely. They are provided with some training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and this means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

The pharmacy had two sections, one dealing with the 'hub and spoke' model, and one with the online sales. There was one pharmacist, one pre-registration trainee, one ACT and four dispensers working in the pharmacy hub section. And there was one pharmacist, four ‘pickers’ and three office team members working in the online pharmacy section. Most team members had completed an accredited course for their role and the rest were undertaking training.

The pre-registration trainee was working at the pharmacy so that they could demonstrate some of the required competencies. They had already passed the pre-registration exam. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

People had to complete questionnaire if they wished to purchase a pharmacy-only medicine online and this was reviewed by a pharmacist before being supplied. The pharmacist said that she would contact a person if she had a query about a medicine which had been ordered online. Additional questionnaires were emailed to people for specific medicines to ensure that these were being supplied safely. Procedures were in place to monitor the sales and subsequent re-ordering of higher-risk medicines. The pharmacy could check the person’s order history using their account details. And regular audits were carried out for medicines sent to a specific address or to a named person. The pharmacy regularly reviewed which medicines were suitable to be offered for sale online. One medicine had been removed from sale due to the potential for this to be misused. The pharmacy routinely verified payment methods and checked for fraudulent activity.

The pharmacists and ACT were aware of the continuing professional development requirement for the professional revalidation process. The ACT said that team members were not provided with ongoing structured training on a regular basis, but they did receive some. They had recently undertaken some training about the EU Falsified Medicines Directive. Training records had been kept previously, but these had not been kept up to date recently.

The pharmacist working in the online section explained what had happened when a person had ordered a pharmacy-only medicine, but she had not authorised the supply as it was not licensed for use for the reason that they had stated. She was able to recommend an alternate medicine which was suitable for the person and she referred them to their GP for further advice. The pharmacist working in the hub section said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

Team members had yearly appraisals and performance reviews. They said that they felt comfortable

about discussing any issues with the pharmacists or making any suggestions. And they passed on information informally during the working day. The pharmacy regularly received updates and information from the pharmacy's head office. Targets were not set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can contact the pharmacy and speak with the pharmacist in private.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Air-conditioning was available and the room temperature was suitable for storing medicines.

The consultation room was used for private services such as vaccinations. The room was upstairs and it was not accessible to wheelchair users. There were chairs and a desk and a sink was available in the adjacent kitchen area. Blinds were available to use to cover the external windows if needed. Low-level conversations in the consultation room could not be heard from outside the room. The pharmacy carried out relatively low numbers of vaccinations and there were local pharmacies which were more accessible if needed.

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. The pharmacy 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.

Inspector's evidence

The online pharmacy services and hub were not physically accessible to people using the pharmacy. Medicines were sent by recorded delivery in discreet packaging. The pharmacy website provided details about the delivery services, including contact phone numbers for people to use if they had any queries about their delivery. There were separate phone lines for the online pharmacy and the hub. The ACT explained that the pharmacy hub usually contacted the care homes using email, so that there was a full audit trail for the communication. The pharmacy's website provided details about some ailments and recommended medicines which may be able to treat them.

Orders for online sales of medicines were printed and team members selected stock against these. The pharmacy-only medicines were passed to the pharmacist for checking. Once these had been authorised, the items and paperwork were then packed, scanned and weighed. This helped to ensure that only the items on the order were in the packaging. It the parcel was not the expected weight, this would be highlighted and passed to the pharmacist to check.

The pharmacist said that any clinical checks for prescriptions were carried out at the 'spoke' pharmacy. Prescriptions for cytotoxic medicines were highlighted, so that these were flagged thought the dispensing and checking processes. The pharmacist said that prescriptions for these medicines were checked by a pharmacist before the medicines were supplied. The ACT explained that fridge items were mostly dispensed at the spoke pharmacies. Fridge items for the care homes and nursing homes were kept in blue clear plastic bags to aid identification and CDs were kept in red clear plastic bags. This helped the drivers to identify these medicines and highlight these when handing them over. 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. The ACT said that the relevant patient information leaflets and warning cards were supplied every time the medicine was dispensed.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was marked. There were no date-expired items found in with dispensing stock. The pharmacy kept lists for short-dated items and these were removed from dispensing stock around one month before they were due to expire. The pharmacy was in the process of implementing the use of a dispensing robot. The pharmacist explained that it was currently being trialled to check that it was accurately dispensing medicines. He said that the robot took a photograph of each medicine, weighed and measured them and the colour and description was added. The medicines were dispensed into a 'pod' which was labelled and then placed into the robot. The robot was able to detect any errors when the 'pod' was placed into the machine. The pharmacy had carried out a few trial runs on the system and the pharmacist said that he was going to provide feedback to the provider. The pharmacy did not have part-

dispensed prescriptions. Items were not sent to the care homes or pharmacies until all items had been dispensed.

The ACT said that assessments for the people who use the service to show that they needed the packs were carried out at the spoke pharmacies. The pharmacy did not order prescriptions on behalf of people who received their medicines in multi-compartment compliance packs; this was managed by the spoke pharmacies. Prescriptions were received into the hub in a sealed envelope with 'required by' date. The ACT said that these were received in advance so that any issues could be addressed before people needed their medicines. The pharmacy had access to the pharmacies medication records (PMR) and could check information and print the backing sheets. The ACT said that the spoke pharmacies should keep a record for each person which should include any changes to their medication and keep any hospital discharge letters for future reference. She said that team members routinely checked the PMR to ensure that any changes were highlighted during the dispensing and checking processes. 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 and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

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; two signatures were recorded.

Deliveries to the care homes were made by delivery drivers. The pharmacy obtained people's signatures for deliveries of CD medicines and these were recorded in a way so that another person's information was protected. The pharmacist explained that the pharmacy was in the process of implementing a delivery signature system for all other deliveries to the care homes and nursing homes. This would make it easier for the pharmacy to show that the medicines were safely delivered. Delivery attempts were made during the care home's operating hours of all recipients so that items were not 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. 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.

The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive and it was being fully used. Team members had undertaken training on how the system worked and there were written procedures available.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available but not for volumes less than five millilitres. The ACT said that she would order a suitable measure. Triangle tablet counters were available and clean; 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. Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order

Fridge temperatures were checked daily; 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 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.